

A MAJOR QUESTION: HAS OSHA MISSED ITS OPPORTUNITY TO REGULATE MEDICAL RESIDENT DUTY HOURS?

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Medical residents fall into a category of workers perpetually overlooked by the Occupational Safety and Health Administration (“OSHA”) due to their dual role as employee and trainee. Despite OSHA’s knowledge of the often life-threatening safety and health hazards medical residents face in the workplace pursuant to their uniquely arduous working conditions—most notably their duty hours—it has declined repetitiously to exercise its authority under the Occupational Safety and Health Act to intervene. While OSHA’s past failure to intervene should not hinder it from exercising its statutory authority to protect medical residents in the workplace today, SCOTUS’ recent efforts to curb administrative action under its major questions doctrine likely render any action in this previously unregulated area futile. Still, present-day action by OSHA and a subsequently well-publicized SCOTUS rejection of such action has the potential to spur a systemic movement capable of catalyzing the desired change, albeit via an alternative mechanism. It follows that OSHA should still act to regulate the medical resident workplace, notwithstanding inevitable SCOTUS scrutiny, because its very attempt to do so can ultimately result in the changes necessary to further protect medical residents from falling victim to the unique working conditions plaguing their profession.

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INTRODUCTION

They told him he was in “duress.”

This particular first-year medical resident, after having just completed an excruciating stretch of hospital coverage in his first three months of residency, could not stop himself from unleashing what would ultimately become a career-altering, fury of frustration on his Program Director. In mere seconds, he barreled through his concerns, which overwhelmingly focused on his sense of incapacitating helplessness. He expressed feeling as though he was stuck inside a system that simply did not care about its employees’ well-being. Rather than responding empathetically, however, his Program Director opted to detail what she felt were the multitude of advancements the program had already made in this realm. In what could have been a reckoning of further opportunities for growth, the Program Director instead elected to minimize the resident’s experience while simultaneously recasting his grievances not as a representation of an oppressive system but rather as evidence of the resident’s abnormal reaction to an otherwise copasetic one.

After a week-long “cooling off” period, the resident voluntarily resigned from his program and, with that choice, relegated himself to a future without medicine. What he retained, however, was far more important than any career could ever be: his life.

And I would know because the resident, who left it all behind, is me.

One would be right to question why I would choose to detail such a seemingly benign anecdote as an introduction to a far grimmer reality: the United States’ ongoing medical resident (“resident”) suicide epidemic.¹ Rather than an attempt at self-indulgence, however, I share my personal experience with the graduate medical education (“GME”) system to offer perspective. I recognize how profoundly fortunate I am to be able to share my story because so many of my peers, who ultimately succumbed to GME’s longstanding oppression, no longer have that option.² Today, I write not for myself but for them.

¹ See Jeannie Aschkenasy, *Doctors and Suicide*, SCI. AM. (Dec. 31, 2019), <https://blogs.scientificamerican.com/observations/doctors-and-suicide/> [<https://perma.cc/W2HB-VVWJ>] (highlighting “a major occupational hazard in medical training: the high suicide rate of medical students, residents and physicians”); see also Molly C. Kalmoe, et al., *Physician Suicide: A Call to Action*, 116 MO. MED. 211, 211 (2019) (noting that mental illness and burnout—risk factors for death by suicide when untreated—are “epidemic in physicians and medical trainees”).

² See, e.g., Michael Gartland, *NYC Doctor Suicides Raise Concerns About Treatment of Resident Physicians at Bronx Hospital*, N.Y. DAILY NEWS, <https://www.nydailynews.com/new-york/ny-suicides-residency-lincoln-medical-center-south-bronx-20210718-eiq3tepxx>

Physician suicide, in general, is not a novel concept.³ Physicians, like many other high-achieving professionals operating in chronically stressful work environments, lose their lives to suicide at rates significantly higher than the general population.⁴ Much has been hypothesized about the ostensible causes of these deaths—ranging from underlying mental illness to the effects of chronic fatigue.⁵ But one thing is certain: the United States simply does not actively protect the learned professional from becoming a suicide statistic.

There is, of course, the argument that the seasoned, learned professional has the means to control the circumstances contributing to their⁶ mental anguish, such that they can mitigate the risk of succumbing to suicide. The same simply cannot be said for the resident who, by virtue of their dual role as an employee and graduate trainee, is at the absolute whim of their residency program—an entity, itself, at the whim of the Accreditation Council for Graduate Medical Education (“ACGME”).⁷

The resident who does not acquiesce to the ever-demanding, if not overwhelming, expectations of their residency program—expectations defined by the unique business demands of their particular program in conjunction with the ACGME’s overarching accreditation standards—risks discipline, a delay in program progression (e.g., from PGY-1 to PGY-2, etc.), or even termination. Termination from a residency program is essentially a career-ending, scarlet letter for the affected resident who almost certainly will not be able to gain employment in another residency program, and thus, will not be able to practice medicine in all but a few states.⁸

bcwdacip3au4624m4-story.html [https://perma.cc/J5MH-48CZ] (last updated July 18, 2021, 2:00 AM) (detailing at least two medical resident suicides at the same Bronx hospital during the same academic year).

³ Kalmoe et al., *supra* note 1, at 211 (“Documentation of increased suicide risk among physicians dates to the 19th century.”).

⁴ *Id.* at 212.

⁵ *See id.*

⁶ Throughout this Note, I elect to utilize the singular “they,” “their,” and “them,” rather than binary gendered pronouns, where appropriate.

⁷ *See What We Do*, ACGME, <https://web.archive.org/web/20230331211211/https://www.acgme.org/What-We-Do/Overview/> [https://perma.cc/LM7F-KXEG].

⁸ As of 2022, Missouri, Utah, Arizona, Arkansas, and Kansas were the only states that allowed medical schools graduates without residency training to practice primary care in collaboration with a fully licensed physician—though with most statutorily limiting the time such graduates can practice in this capacity. *See, e.g.*, MO. REV. STAT. § 334.036 (2023); UTAH ADMIN. CODE 58-67-302.8 (1)(c) (2022); ARIZ. REV. STAT. § 32-1432.04 (2023); Sarah L. Geiger, *The Ailing Labor Rights of Medical Residents: Curable Ill or a Lost Cause?*, 8 U. PA. J. LAB. & EMP. L. 523, 523 (2006) (“Most doctors cannot work in private practice until they have completed an accredited residency program.”).

Acknowledging this harsh reality, the medical resident has no other option than to accept their residency program's terms of employment.⁹ There is no negotiation nor compromise, simply a unilateral offer by the residency program with no choice for the medical resident but to accept the terms as they are if they want to continue to pursue a career in medicine.¹⁰ This organizational structure, thus, renders the resident simultaneously powerless and acutely vulnerable to their residency program's workplace conditions—conditions that continue to be so grueling that residents inevitably become susceptible to debilitating mental illness and suicide.¹¹

The plight of medical residents has not gone on deaf ears.¹² There have, in fact, been historical movements to improve medical resident working conditions—most of which, unfortunately, have failed to achieve the desired ends.¹³ In 2001, Public Citizen issued a petition to the Occupational Safety and Health Administration (“OSHA”) requesting that OSHA exercise its authority under the Occupational Safety and Health Act of 1970 (“OSH Act” or “the Act”) to develop and promulgate standards restricting resident duty hours—an initiative aimed at lessening the effects of chronic fatigue on residents, including, in the most extreme cases, mental health conditions rendering residents susceptible to suicide.¹⁴

In 2003, in apparent defensive reaction to mounting public pressure, as well as the theoretical threat of governmental intrusion into GME, the ACGME formally adopted duty hour standards, in addition to several other guidelines, to appease its most vocal critics.¹⁵ OSHA, in turn, declined to

⁹ See Robert N. Wilkey, *The Non-Negotiable Employment Contract—Diagnosing the Employment Rights of Medical Residents*, 44 CREIGHTON L. REV. 705, 718 (2011).

¹⁰ *Id.* (“[T]he appointment contract is for all intent and purpose, a non-negotiable contract.”).

¹¹ See Matthew D. Weaver et al., *The Association Between Resident Physician Work Hour Regulations and Physician Safety and Health*, 133 AM. J. MED. e343, e348–49 (2020) (noting that suicide is one of the leading causes of death in medical residents).

¹² See Robert R. Elder, *Expanded Hospital Liability Under the Federal False Claims Act: An Unexpected Solution to the Resident Duty Hour Controversy*, 5 IND. HEALTH L. REV. 53, 56 (2008).

¹³ *Id.* (“[R]eformers’ attempts to change Resident duty hours have most often been thwarted by well-meaning medical educators’ [sic] intent on preserving the sanctity of the age-old master apprentice educational model.”).

¹⁴ See Anandev Gurjara et al., *Petition Requesting Medical Residents Work Hour Limits*, PUB. CITIZEN (Apr. 30, 2001), <https://www.citizen.org/article/petition-requesting-medical-residents-work-hour-limits/> [<https://perma.cc/A5NH-UYNF>] [hereinafter *2001 Petition*]; see also Peter Lurie. & Sidney M. Wolfe, *Letter on Medical Resident Duty Hours*, PUB. CITIZEN (Aug. 1, 2002), <https://www.citizen.org/article/letter-on-medical-resident-duty-hours/> [<https://perma.cc/42PN-AZ8H>] (referencing *2001 Petition*).

¹⁵ Lurie & Wolfe, *supra* note 14 (“The major purpose of the ACGME’s proposed requirements for resident work hours is plain: to forestall . . . regulation from the Occupational Safety and Health Administration (OSHA), actions we have sought.”).

intervene, concluding that the ACGME was in the best position to balance the safety, health, and training requirements of medical residents.¹⁶

In 2010—believing ACGME’s efforts to protect the safety and health of residents had been insufficient—Public Citizen renewed its petition for OSHA to exercise its authority over the resident workplace.¹⁷ OSHA, again, declined to intervene, opting instead to defer to the ACGME’s expertise.¹⁸ The ACGME continues to make limited modifications to its residency workplace standards,¹⁹ though none have been as significant as those it promulgated in 2003.²⁰ Its express apprehension to further limit duty hours, in particular, is apparently derived in its concerns that (1) residents’ training will suffer as their time in the hospital decreases and (2) patient safety will be threatened with the resulting increase in patient handoffs and reduced continuity of care²¹—all of this despite the ACGME’s knowledge of the ongoing medical

¹⁶ See *OSHA Should Use Its Existing Authority to Enforce Work Hours for Doctors-in-Training, Public Citizen Tells Agency*, PUB. CITIZEN (Nov. 3. 2011), <https://www.citizen.org/news/osha-should-use-its-existing-authority-to-enforce-work-hours-for-doc-tors-in-training-public-citizen-tells-agency/> [<https://perma.cc/CKH2-7XG4>] [hereinafter *OSHA Should Use Its Existing Authority*] (recognizing OSHA’s past rejections of requests to regulate medical resident duty hours); see also Elder, *supra* note 12, at 61 (“OSHA rationalized its decision to rely on the ACGME’s Resident work hour guidelines stating that ‘resident work hour issues would be better addressed by entities with experience both in patient care and employee health. Thus, because the ACGME has extensive experience in patient health, employee health, and medical education and training . . . the ACGME was in a better position to address the issue.’”) (quoting W. Paige Hren, *Is It the End of an Era or the Beginning of an Error? The American Medical Association Finally Approves Work Hour Limits for Overworked & Sleep Deprived Medical Residents: Should OSHA Still Step In?*, 23 J. NAT’L ASS’N ADMIN. L. JUDGES 457, 467 (2003)).

¹⁷ Charles M. Preston et al., *Petition to Reduce Medical Resident Work Hours*, PUB. CITIZEN (Sept. 2, 2010), <https://www.citizen.org/wp-content/uploads/migration/1917.pdf> [<https://perma.cc/AZQ7-YWXR>] [hereinafter *2010 Petition*]; see also *OSHA Should Use Its Existing Authority*, *supra* note 16.

¹⁸ *OSHA Should Use Its Existing Authority*, *supra* note 16.

¹⁹ Medical residents in the United States may work a maximum of eighty hours per week averaged over a four-week period; should have at least eight hours off “between scheduled clinical work and education periods;” must have at least fourteen hours off after in-house twenty-four-hour call; and must have one day per seven days off, again, averaged over a four-week period. *ACGME Common Program Requirements (Residency)*, ACGME (Jul. 1, 2022), https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2022v3.pdf [<https://perma.cc/C85B-UNGA>].

²⁰ *But see* Weaver et al., *supra* note 11, at e348 (recognizing that the ACGME’s 2011 standard limiting extended-duration shifts for first-year medical residents “were followed by marked improvements in resident safety” including reduced rates of “percutaneous injuries” and “attentional failures”).

²¹ See Dori Pagé Antonetti, Comment, *A Dose of Their Own Medicine: Why the Federal Government Must Ensure Healthy Working Conditions for Medical Residents and How Reform Should Be Accomplished*, 51 CATH. UNIV. L. REV. 875, 877 (2002); see also Elder, *supra* note 12, at 59 (detailing “[a]rguments [m]ade by [p]roponents of [t]raditional [r]esident [d]uty [h]ours”).

resident suicide epidemic and the well-established inverse relationship between resident duty hours and their mental health.²²

In this Note, I argue, consistent with at least one of my peers,²³ that OSHA continues to have, and should exercise, the authority to develop and promulgate workplace standards regulating resident duty hours because the ACGME's standards have been inadequate in addressing the ongoing medical resident suicide epidemic.²⁴ I do this while exploring the potential futility of such an exercise of OSHA's authority knowing that such an initiative would surely reach the modern-day Supreme Court of the United States, ripe with a clear conservative supermajority, that has indicated its intention to limit administrative oversight as much as possible.²⁵

Part I of this Note will explore the connection between medical resident duty hours and the development of chronic fatigue, mental illness, and suicidality. Part II will introduce the ACGME—the primary organization responsible for medical resident oversight—and discuss its ostensible efforts to balance residents' educational goals with their health and safety needs. Part III will detail OSHA's authority under the OSH Act to regulate workplace conditions and emphasize the great deference federal courts have historically given OSHA in developing and promulgating regulations in the healthcare workplace. Part IV will highlight and reemphasize OSHA's authority to regulate medical resident duty hours. Part V will consider the futility of OSHA exercising this authority under SCOTUS's recent invocation of its ever-developing “major questions doctrine.” Finally, Part VI will posit that, despite the

²² See Kathlyn E. Fletcher et al., *Patient Safety, Resident Education and Resident Well-Being Following Implementation of the 2003 ACGME Duty Hour Rules*, 26 J. GEN. INTERNAL MED. 907, 916 (2011) (highlighting improvements in resident self-reported symptoms of burnout following the ACGME's 2003 duty hour restrictions but cautioning that “rates of depression do not seem to have changed between the pre-2003 period and the post-2003 period”).

²³ W. Paige Hren, *Is It the End of an Era or the Beginning of an Error? The American Medical Association Finally Approves Work Hour Limits for Overworked & Sleep Deprived Medical Residents: Should OSHA Still Step In?*, 23 J. NAT'L ASS'N ADMIN. L. JUDGES 457, 479 (2003) (ACGME's mission “to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training . . . can only be accomplished by allowing OSHA . . . to take over the responsibility of regulating and enforcing resident work hours.”).

²⁴ See Elder, *supra* note 12, at 57 (“ACGME restrictions on Resident duty hours have been only marginally successful in curtailing the medical community's habit of requiring Residents to work dangerously long duty hours.”).

²⁵ See, e.g., *Biden v. Nebraska*, 143 S. Ct. 2355, 2368–69 (2023) (holding that the Secretary of Labor exceeded his authority under the HEROES Act to forgive up to \$20,000 in student loans for borrowers with income below \$125,000); *Nat'l Fed'n of Indep. Bus. v. Dep't of Lab.*, 595 U.S. 109, 120 (2022) (holding that OSHA may not use its emergency authority to issue widespread COVID vaccine mandates in the workplace); *West Virginia v. Env't Prot. Agency*, 142 S. Ct. 2587, 2610 (2022) (invoking the “major questions doctrine” to hold that the EPA overstepped its authority in enacting Section 111(d) of the Clean Air Act because it “empower[ed] [the EPA] to substantially restructure the American energy market”).

inevitability of SCOTUS rendering such an act administrative overreach, OSHA's theoretical choice to regulate medical resident duty hours has the potential to inspire a movement capable of catalyzing the desired change.

I. LINKING MEDICAL RESIDENT DUTY HOURS TO CHRONIC FATIGUE, MENTAL ILLNESS, AND SUICIDALITY

Medical residents notoriously work excruciatingly long hours—routinely up to eighty hours in any given week—throughout their residency programs.²⁶ It should come as no surprise that these virtually incomparable demands have repeatedly been linked to a number of deleterious effects on resident physical and mental health. Specifically, medical resident duty hours have been correlated with an increased risk of car accidents, long-term cardiovascular disease, poor attention, decreased reaction time, feelings of helplessness, mental disturbance (including burnout), mental illness (e.g., major depression), and suicidality.²⁷

Speaking broadly, sleep—as innately controlled by the circadian rhythm—is fundamentally necessary to optimize physical and mental health.²⁸ The human body relies on the sleeping hours for a number of vital biological processes including cellular repair, digestion, memory formation, and the overall reset of homeostasis.²⁹ Disruption of innate sleeping patterns disrupts these vital biological processes, essentially placing the body in a deficit that it will inevitably seek to counteract over future sleep cycles.³⁰ However, when disruption of sleeping patterns becomes chronic (i.e. chronic fatigue), the body can no longer overcome the perpetual deficit, leading to a state of disequilibrium—characterized by inflammation, decreased

²⁶ See Anupam B. Jena, *Is an 80-Hour Workweek Enough to Train a Doctor?*, HARV. BUS. REV. <https://hbr.org/2019/07/is-an-80-hour-workweek-enough-to-train-a-doctor> [<https://perma.cc/3VAU-CNTS>] (last updated July 12, 2019); see also *Accreditation Council for Graduate Medical Education Fact Sheet*, ACGME, https://www.acgme.org/globalassets/PDFs/Fact_Sheet.pdf [<https://perma.cc/ZG4W-F9AC>] [hereinafter *ACGME Fact Sheet*] (highlighting that medical residency program durations range from three years to seven years—time frames that do not take into account frequent medical resident pursuit of fellowship sub-specialty training, which can extend residency training one to three more years under the same, if not more arduous, working conditions).

²⁷ See Weaver et al., *supra* note 11, at e349.

²⁸ See Michele L. Okun, *Biological Consequences of Disturbed Sleep: Important Mediators of Health?*, 53 JAPANESE PSYCH. RSCH. 163, 169 (2011); see also Eric Suni & Ealena Callender, *What Happens When You Sleep?*, SLEEP FOUND., <https://www.sleepfoundation.org/how-sleep-works/what-happens-when-you-sleep> [<https://perma.cc/D5TR-L8XH>] (last updated Aug. 29, 2022).

²⁹ See Okun, *supra* note 28, at 163.

³⁰ See *id.* at 164.

immunity, poor memory formation, cardiovascular compensation, and mental disturbance.³¹

Chronic mental disturbance frequently leads to diagnostic mental illness—most frequently major depression.³² Major depression is characterized by sleep disturbance, anhedonia, feelings of guilt, decreased energy, poor concentration, appetite fluctuations, agitation, and suicidality.³³

While individual circadian rhythms—and thus individual sleep requirements—may vary to some extent, there can be no doubt that working eighty hours in any given week over a period of three or more years will lead unerringly to chronic fatigue.³⁴ While not every individual suffering from chronic fatigue will develop diagnostic mental illness, those with chronic fatigue are statistically at a higher risk than the general population.³⁵ Because mental illness, and more specifically, major depression, is linked with suicidality, those more susceptible to developing mental illness are more likely to experience suicidal ideation.³⁶ This helps explain the ongoing medical resident suicide epidemic.³⁷

³¹ See *id.* at 170; see also Tomas Chamorro-Premuzic, *How Much Is Bad Sleep Hurting Your Career?*, HARV. BUS. REV. (July 27, 2020), <https://hbr.org/2020/07/how-much-is-bad-sleep-hurting-your-career> [<https://perma.cc/QN3A-J7FQ>].

³² See Olivia Remes et al., *Biological, Psychological, and Social Determinants of Depression: A Review of Recent Literature*, 11 BRAIN SCIS. 1633, 1638 (2021) (“Chronic stress can impact the dendrites and synapses of various neurons, and may be implicated in the pathway leading to major depressive disorder.”).

³³ See *Depression: Screening & Assessment*, CTR. FOR ADDICTION & MENTAL HEALTH, <https://www.camh.ca/en/professionals/treating-conditions-and-disorders/depression/depression---screening-and-assessment> [<https://perma.cc/DZ44-FHKD>].

³⁴ See Kapo Wong et al., *The Effect of Long Working Hours and Overtime on Occupational Health: A Meta-Analysis of Evidence from 1998 to 2018*, 16 INT’L J. ENV’T RSCH. & PUB. HEALTH 2102, 2113–14 (2019) (“undoubtedly” linking worker fatigue to “insufficient sleep”).

³⁵ See *Depression and Sleep: Understanding the Connection*, JOHNS HOPKINS MED., <https://www.hopkinsmedicine.org/health/wellness-and-prevention/depression-and-sleep-understanding-the-connection#:~:text=Depression%20and%20sleep%20problems%20are,get%20a%20good%20night's%20sleep.> [<https://perma.cc/2QV2-J2GP>].

³⁶ See Louise Brådvik, *Suicide Risk and Mental Disorders*, 15 INT’L J. ENV’T RSCH. & PUB. HEALTH 2028, 2028 (2018) (“Most suicides are related to psychiatric disease . . .”).

³⁷ See *10 Facts About Physician Suicide and Mental Health*, AM. FOUND. FOR SUICIDE PREVENTION, <https://www.acgme.org/globalassets/PDFs/ten-facts-about-physician-suicide.pdf> [<https://perma.cc/9526-B36R>] (“The suicide rate among male physicians is 1.41 times higher than the general male population. And among female physicians . . . 2.27 times greater than the general female population. . . . Twenty-eight percent of residents experience a major depressive episode during training versus 7–8 percent of similarly aged individuals in the U.S. general population.”).

II. MEDICAL RESIDENT OVERSIGHT AND THE DUAL PRIORITY CONUNDRUM

A. *The Accreditation Council for Graduate Medical Education*

The ACGME was established in 1981 pursuant to a collective initiative from five leading medical organizations: (1) American Medical Association (“AMA”),³⁸ (2) American Board of Medical Specialties (“ABMS”),³⁹ (3) American Hospital Association (“AHA”),⁴⁰ (4) Association of American Medical Colleges (“AAMC”),⁴¹ and (5) the Council of Medical Specialty Societies (“CMSS”)^{42,43} Prior to the ACGME’s establishment, in the early 20th century, each medical specialty board was responsible for oversight of its respective trainees.⁴⁴ Later, Residency Review Committees (“RRCs”) “began evaluating and accrediting education programs in different specialties.”⁴⁵ Finally, the aforementioned five medical organizations agreed that there was a need for a unified body overseeing graduate medical education as a whole.⁴⁶ That unified body is the ACGME.

The ACGME is a private, 501(c)(3), non-profit organization “that sets standards for US graduate medical education . . . programs and the institutions that sponsor them, and renders accreditation decisions based on compliance with these standards.”⁴⁷ As of the 2022 academic year, there were 886 ACGME-accredited institutions sponsoring over 13,000 programs in 182 specialties.⁴⁸ At those 886 ACGME-accredited institutions are nearly 160,000 residents and fellows.⁴⁹ While GME programs need not pursue ACGME accreditation to operate, failing to do so disallows such programs from seeking residency-related funding from the Centers for Medicare and Medicaid Services (“CMS”).⁵⁰ Additionally, residents who graduate from non-ACGME-accredited institutions will be limited in where they can ultimately practice

³⁸ See generally *About*, AM. MED. ASS’N, <https://www.ama-assn.org/about#> [https://perma.cc/LN3Y-HRWS].

³⁹ See generally *Home Page*, AM. BD. MED. SPECIALTIES, <https://www.abms.org/> [https://perma.cc/97EU-WUE].

⁴⁰ See generally *About the AHA*, AM. HOSP. ASS’N, <https://www.aha.org/about> [https://perma.cc/65YK-P8GH].

⁴¹ See generally *About Us*, ASS’N AM. MED. COLLS., <https://www.aamc.org/about-us> [https://perma.cc/RU6D-XKXX].

⁴² See generally *Mission and History*, COUNCIL MED. SPECIALTY SOC’YS, <https://cmss.org/about-cmss/> [https://perma.cc/5X3R-8646].

⁴³ *ACGME Fact Sheet*, *supra* note 26.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ See ACGME, *What We Do*, *supra* note 7.

⁴⁸ *About the ACGME: ACGME by the Numbers*, ACGME, <https://www.acgme.org/about/overview> [https://perma.cc/4ULG-NZGR].

⁴⁹ *Id.*

⁵⁰ *ACGME Fact Sheet*, *supra* note 26.

because some states “require completion of an ACGME-accredited residency program for physician licensure.”⁵¹

The ACGME is governed by its Board of Directors, which is comprised of four members from each of the aforementioned five medical organizations in addition to two medical residents, three representatives of the public, the Chair of the Council of Review Committees (an ACGME committee), one to four residency program directors, and “two non-voting federal representatives appointed by the Department of Health and Human Services and the Veteran’s Administration.”⁵²

B. The ACGME’s Ostensible Efforts to Mitigate the Effects of Chronic Fatigue

Medical residency has been (and continues to be) notoriously taxing. Indeed, the concept of “residency” itself is derived in a historical understanding that medical residents essentially lived at their GME institutions.⁵³ The theory behind “residency” was that medical residents could only learn as much as they saw, so the more time they were at the hospital, the more they learned, and the more their future patients ultimately benefitted.⁵⁴ Of course, the complexity of the medical institution as a whole in those times was profoundly reduced compared to that of the modern day where science, technology, and administrative oversight (and the responsibilities inherent in said oversight) have exponentially evolved.⁵⁵ The role and responsibilities of the medical resident have similarly evolved.

Unfortunately, as is typical of such historically revered professions, the sheer arduousness of the medical resident’s role became ingrained in the system as an apparent rite of passage.⁵⁶ Despite medical resident efforts to informally and formally bargain for better working conditions, it was not until the substantial public outcry and a concomitant pressure campaign of the early

⁵¹ *Id.*

⁵² *Id.* (emphasis added).

⁵³ Deborah Chiaravalloti, *The Origins of Common Medical Terminology and Acronyms*, BD. VITALS (Mar. 6, 2019), <https://www.boardvitals.com/blog/origins-medical-terminology-acronyms/> [<https://perma.cc/S6Z5-YQ22>].

⁵⁴ See *The History of Residency—and What Lies Ahead*, AM. MED. ASS’N (Nov. 19, 2014), <https://www.ama-assn.org/education/improve-gme/history-residency-and-what-lies-ahead> [<https://perma.cc/HBN3-Y94P>] (recognizing that residencies were put in place to give medical residents “sufficient time to pursue problems in depth”).

⁵⁵ See, e.g., Vanessa Rampton et al., *Medical Technologies Past and Present: How History Helps to Understand the Digital Era*, 43 J. MED. HUMANS. 343, 345–46 (2021) (highlighting physicians’ common criticism that the “time-consuming nature of [electronic health records]” has had a deleterious effect on the physician-patient relationship).

⁵⁶ See Pauline W. Chen, *A Medical Student’s Rite of Passage*, N.Y. TIMES (Mar. 19, 2009), <https://www.nytimes.com/2009/03/19/health/19chen.html> [<https://perma.cc/T5AC-RNCL>] (“While medical school may lay the foundation of medical education, it is the residency training, completed in the years after graduation, that creates the practicing doctor.”).

2000s that the medical community started to grasp the gravity of the situation and institute changes—albeit ones that arguably failed to achieve their desired ends.⁵⁷

Most impactful among the various actors engaged in the systemic pressure campaign was Public Citizen—a “nonprofit consumer advocacy organization”⁵⁸ that filed a 2001 petition with OSHA requesting that OSHA exercise its authority under the OSH Act to regulate medical resident duty hours.⁵⁹ The petition referenced OSHA’s “authority under section 3(8)”⁶⁰ of the OSH Act to so regulate residencies “on the grounds that work hours in excess of the requested limits are physically and mentally harmful to medical residents . . . and that a federal work-hour standard is necessary to provide them with safe employment.”⁶¹ It continued, “[r]esearch has connected the typical resident work schedule to harms in three specific areas: motor vehicle accidents, mental health, and pregnancy.”⁶² On mental health specifically, Public Citizen reflected on the connection between “[f]atigue and sleep deprivation caused by excessive work hours” and the alarming rates of clinical depression⁶³ and suicidal ideation in medical residents.⁶⁴ It posited that “reducing work schedules to allow for more sleep should reduce . . . the likelihood of developing depression” and thereby suicidality.⁶⁵

Facing the threat of federal intervention and regulation, the ACGME proposed “common duty hour standards” in 2002, adopting and implementing

⁵⁷ See *Comparison of Proposals to Limit Resident Work Hours*, AM. MED. STUDENT ASS’N (2002), <https://www.citizen.org/wp-content/uploads/1633attachment.pdf> [<https://perma.cc/4LR7-Y6G8>] (providing a table from 2002 comparing models of change for medical resident duty hours proposed by (1) Congress, (2) Public Citizen, (3) ACGME, (4) AMA, and (5) AAMC).

⁵⁸ See *About Us*, PUB. CITIZEN, <https://www.citizen.org/about/> [<https://perma.cc/A3ZS-YC H3>].

⁵⁹ *2001 Petition*, *supra* note 14.

⁶⁰ “The term ‘occupational safety and health standard’ means a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.” 29 U.S.C. § 652(8).

⁶¹ *2001 Petition*, *supra* note 14.

⁶² *Id.*

⁶³ It has been estimated that approximately thirty percent of medical residents experience depression during residency. *Id.* A 2013 study by the National Institute of Mental Health estimated the prevalence of major depression in the general population to be “about 6.7 percent.” Lena H. Sun, *Nearly a Third of New Doctors at High Risk for Depression*, WASH. POST (Dec. 8, 2015, 11:21 AM), <https://www.washingtonpost.com/news/to-your-health/wp/2015/12/08/nearly-a-third-of-new-docs-at-high-risk-for-depression/> [<https://perma.cc/F6AS-EJA7>].

⁶⁴ See *2001 Petition*, *supra* note 14.

⁶⁵ *Id.*

them officially in 2003.⁶⁶ OSHA, in turn, rejected Public Citizen's petition to intervene, instead deferring to the ACGME who it believed was in the best position to regulate duty hours while considering the impacts on resident training.⁶⁷ Public Citizen re-petitioned OSHA in 2010 citing considerable loopholes⁶⁸ in the ACGME work-hour standards and its ongoing concerns for resident safety.⁶⁹ Though OSHA expressed concern "about medical residents working extremely long hours" and "evidence linking sleep deprivation" with decreased worker safety, OSHA, again, rejected Public Citizen's petition, thereby declining to exercise its authority to regulate medical resident duty hours.⁷⁰

Though the ACGME regularly updates its common standards pursuant to its own research, which includes annual surveys from ACGME-accredited institutions, it has not made any changes to resident duty hours as seemingly sweeping as the standards it adopted in 2003—despite its knowledge that those standards have inadequately addressed the well-documented workplace safety and health hazards medical residents continue to face.⁷¹ The ACGME frequently cites its responsibility to balance the dueling interests of mitigating the "negative effects of chronic sleep loss" with its obligation to provide "adequate time for patient hand-off and didactic learning" as a basis for declining to further restrict resident duty hours.⁷²

⁶⁶ See Hren, *supra* note 23, at 467–68 ("Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call . . . Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.") (quoting the 2003 ACGME standards).

⁶⁷ See *OSHA Denies Petition to Reduce Work Hours for Doctors-in-Training*, PUB. CITIZEN (Oct. 10, 2002), <https://www.citizen.org/news/osha-denies-petition-to-reduce-work-hours-for-doctors-in-training/> [<https://perma.cc/6U8K-EHBR>].

⁶⁸ See Hren, *supra* note 23, at 472 (enumerating "inherent loopholes in ACGME's duty hours standards").

⁶⁹ See *2010 Petition*, *supra* note 17, at 15–16.

⁷⁰ See *Statement by US Department of Labor's OSHA Assistant Secretary Dr. David Michaels on Long Work Hours, Fatigue and Worker Safety*, OSHA (Sept. 2, 2010), <https://www.osha.gov/news/newsreleases/statement/09022010> [<https://perma.cc/EMP9-R8Y4>].

⁷¹ See *Improving Physician Well-Being, Restoring Meaning in Medicine*, ACGME, <https://www.acgme.org/meetings-and-educational-activities/physician-well-being/> [<https://perma.cc/H8R6-3752>] (highlighting the fact that, "[i]n 2017, the ACGME revised its Common Program Requirements . . . to address [medical resident and fellow] well-being more directly and comprehensively," in apparent recognition of the "psychological, emotional, and physical" challenges medical residents and fellows continue to face in the workplace).

⁷² See, e.g., *The ACGME's Approach to Limit Resident Duty Hours 12 Months After Implementation: A Summary of Achievements*, ACGME, https://www.acgme.org/globalassets/PFAssets/PublicationsPapers/dh_dutyhoursummary2003-04.pdf [<https://perma.cc/V5RK-VY45>].

In 2017, recognizing the persistence of medical resident “burnout”⁷³ and ongoing internal threats to “physician well-being,” the ACGME revised its “Common Program Requirements [to require residency programs] . . . to address [resident] well-being more directly and comprehensively.”⁷⁴ It posited that institutions could do this, not by further restricting duty hours, but through a multipronged effort which may include (1) increasing diversity and inclusion and (2) encouraging leadership at each institution to find ways to “advocate[]” for well-being within the particular bounds of their respective programs.⁷⁵ Sadly, these efforts have been insufficient to curb the systemic persistence of medical resident mental health disturbance and related suicidality.⁷⁶

III. THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

A. *The Occupational Safety and Health Act of 1970*

Congress enacted the OSH Act of 1970, pursuant to its Commerce Clause powers,⁷⁷ “[t]o assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act.”⁷⁸ The Act authorizes “the Secretary of Labor to set mandatory occupational safety and health standards;”⁷⁹ creates the “Occupational Safety and Health Review Commission for carrying out adjudicatory functions;”⁸⁰ provides for “research in the field of occupational safety and health, including the psychological factors involved;”⁸¹ allows for the exploration of “causal connections between [latent] diseases and work;”⁸² and ultimately provides “for the development and promulgation of occupational safety and health standards.”⁸³

⁷³ “Burnout” is an arguably more *friendly* moniker for depressed mood or the signs and symptoms of clinical depression. See Mayo Clinic Staff, *Job Burnout: How to Spot It and Take Action*, MAYO CLINIC (June 5, 2021), <https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/burnout/art-20046642> [https://perma.cc/3CN5-GW36] (“Some experts think that other conditions, such as depression, are behind burnout.”).

⁷⁴ See *Improving Physician Well-Being, Restoring Meaning in Medicine*, *supra* note 71.

⁷⁵ *Id.*

⁷⁶ See *supra* Part I.

⁷⁷ “Congress declares it to be its purpose and policy, through the exercise of its powers to regulate commerce among the several States . . . to assure so far as possible every working man and woman in the Nation safe and healthful working conditions . . .” 29 U.S.C. § 651(b).

⁷⁸ 29 U.S.C. § 651.

⁷⁹ 29 U.S.C. § 651(b)(3).

⁸⁰ *Id.*

⁸¹ 29 U.S.C. § 651(b)(5).

⁸² 29 U.S.C. § 651(b)(6).

⁸³ 29 U.S.C. § 651(b)(9).

By its very nature, Congress intended for the Act to be profoundly broad in its reach. Consider the Act's definitions of "employer" and "employee," to whom the Act specifically applies. An "employer" is "a person engaged in a business affecting commerce who has employees;"⁸⁴ an "employee," however circular it may sound, is defined as "an employee of an employer who is employed in a business of his employer which affects commerce."⁸⁵ The Act specifically exempts from its mandates United States (except the United States Postal Service ("USPS")), state, and state political subdivision employers.⁸⁶ OSHA additionally defers to other federal or state regulatory bodies who have direct regulatory control over certain industries (e.g., the Federal Aviation Administration ("FAA") for the aviation industry, the Department of Transportation ("DOT") for the interstate transport industry, etc.) regarding safety and health standards specific to employers within those industries.⁸⁷ Thus, any non-public employer (except the USPS) who is not subject to regulation by another federal or state regulatory body that has at least one employee is subject to the Act. Courts apply the common law agency Right to Control Test to ascertain whether the Act applies in cases or controversies where employment status is at issue.⁸⁸

B. *Development and Promulgation of OSHA Standards and the General Duty Clause*

The OSH Act defines an "occupational safety and health standard" as a "standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment."⁸⁹ Though courts often conflate "safety" and "health" standards, the Act expressly indicates the legislature's acknowledgment that the two "present

⁸⁴ 29 U.S.C. § 652(5).

⁸⁵ 29 U.S.C. § 652(6).

⁸⁶ 29 U.S.C. § 652(5).

⁸⁷ See *Who Is Exempt from OSHA?*, AMUNDSEN DAVIS (Dec. 11, 2020), <https://www.oshalegal.com/who-is-exempt-from-osh/> [<https://perma.cc/7UUW-5CJ3>].

⁸⁸ The Right to Control Test is a balancing test that considers a non-exhaustive list of factors, none singly dispositive, including: (1) "[t]he skills required [to perform the work]," (2) "[t]he source of the instrumentalities and tools," (3) "[t]he location of the work," (4) "[t]he duration of the relationship between the parties," (5) "[w]hether the hiring party has the right to assign additional projects to the hired party," (6) "[t]he extent of the hired party's discretion over when and how long to work," and (7) "[t]he method of payment." Todd Lebowitz, *What Are Right to Control Tests?*, WHO IS MY EMPLOYEE?: EXPLORING INDEPENDENT CONTRACTOR MISCLASSIFICATION & JOINT EMPLOYMENT ISSUES (Dec. 29, 2016), <https://whoismyemployee.com/2016/12/29/what-are-right-to-control-tests/> [<https://perma.cc/6BGU-Z97X>] (citing *Nationwide Mutual Ins. Co. v. Darden*, 503 U.S. 318, 323 (1992)).

⁸⁹ 29 U.S.C. § 652(8). Recall that this was the clause to which Public Citizen referred in its 2001 and 2010 OSHA petitions to substantiate OSHA's authority to regulate medical resident duty hours. Elder, *supra* note 12, at 56 n.6.

problems often differ[] from” one another⁹⁰—although the distinguishing features rarely appear in practice.

The Act provides for two general means of developing and promulgating safety and health standards: (1) via the standard development procedure typical of administrative agencies,⁹¹ and (2) in enforcement actions, most frequently related to General Duty Clause violations.⁹² In the typical case, “OSHA can begin standards-setting procedures on its own initiative, or in response to petitions from other parties.”⁹³ “If OSHA determines that a specific standard is needed,” it may call on any number of advisory committees to “develop specific recommendations,” which it will in turn use to solidify its proposal.⁹⁴ OSHA then publishes its intentions to establish a new standard in the Federal Register as a “Notice of Proposed Rulemaking,” or even earlier as an “Advance Notice of Proposed Rulemaking,” at which point interested parties may submit comments, “written arguments[,] and pertinent evidence.”⁹⁵ After the close of the “comment period,” OSHA must publish either the final text of the standard it wishes to adopt or “a determination that no standard or amendment needs to be issued.”⁹⁶

OSHA, via the Secretary of Labor, may also establish a standard specific to an employer pursuant to its authority under the General Duty Clause.⁹⁷ The General Duty Clause provides that “[e]ach employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.”⁹⁸ OSHA most often exercises this authority in enforcement actions against employers it alleges have failed to provide

⁹⁰ See 29 U.S.C. § 651(6).

⁹¹ See Mark A. Rothstein, *The OSHA COVID-19 Case and the Scope of the Occupational Safety and Health Act*, 50 J.L. MED. & ETHICS 368, 369 (2002) (“The procedure for promulgating new occupational safety and health standards under the OSH Act is arduous, resource intensive, and excruciatingly slow.”).

⁹² OSHA additionally has authority to issue “Emergency Temporary Standards,” which it historically has only seldom invoked. *OSHA Standards Development*, OSHA, <https://www.osha.gov/laws-regs/standards-development> [<https://perma.cc/Q7H2-5NDH>]; see also, e.g., Nat’l Fed’n of Indep. Bus. v. Dep’t. of Lab., 595 U.S. 109, 120 (2022) (analyzing whether OSHA overstepped its authority in establishing an emergency COVID-19 mandate for all employers with 100 or more employees).

⁹³ See *OSHA Standards Development*, *supra* note 92.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ See Adele L. Abrams, Esq., CMSP, *OSHA’s General Duty Clause: A Guide to Enforcement and Legal Defenses*, AM. SOC’Y OF SAFETY PROS., https://www.assp.org/docs/default-source/standards-documents/osha%27s-general-duty-clause---abrams.pdf?sfvrsn=89cdb147_2 [<https://perma.cc/G2TQ-QC5N>] (noting that the General Duty Clause was “intended to serve as a ‘gap filler’ to address recognized hazards that [OSHA] has not yet regulated.”).

⁹⁸ 29 U.S.C. § 654(a)(1); see also *Usery v. Marquette Cement Mfg. Co.*, 568 F.2d 902, 909 (2d Cir. 1977).

workplaces free of recognized hazards “‘that are causing or are likely to cause death or serious physical harm’” to employees.⁹⁹

To establish a violation of the General Duty Clause, the Secretary [of Labor] must establish that: (1) an activity or condition in the employer’s workplace presented a hazard to an employee, (2) either the employer or the industry recognized the condition or activity as a hazard, (3) the hazard was likely to or actually caused death or serious physical harm, and (4) a feasible means to eliminate or materially reduce the hazard existed.¹⁰⁰

“In other words, ‘the *Secretary* must prove that a reasonably prudent employer familiar with the circumstances of the industry would have protected against the hazard in the manner specified by the Secretary’s citation.’”¹⁰¹ Ultimately, where the Secretary of Labor is successful in meeting the Department’s burden, the General Duty Clause “enables the Federal Government to provide for the protection of employees who are working under such *unique* circumstances that no standard has yet been enacted to cover th[e] situation.”¹⁰²

C. OSHA’s Authority to Regulate the Healthcare Workplace Has Been Reaffirmed

With the nearly infinite ways in which workers may be injured in the healthcare workplace, it should come as no surprise that OSHA has consistently exercised its authority to develop and promulgate standards in this domain to protect healthcare worker safety and health.¹⁰³ Courts, in apparent acknowledgment of the particularly dangerous and/or hazardous conditions the healthcare workplace poses, have all but consistently granted great deference to OSHA in determining the reasonable means to mitigate such conditions.¹⁰⁴

⁹⁹ See, e.g., *SeaWorld of Fla. v. Perez*, 748 F.3d 1202, 1207 (D.C. Cir. 2014) (quoting 29 U.S.C. § 654(a)(1)); *Pratt & Whitney Aircraft v. Sec’y of Lab.*, 649 F.2d 96, 97–98 (2d Cir. 1981) (quoting 29 U.S.C. § 654(a)(1)).

¹⁰⁰ *Seaworld*, 748 F.3d at 1207 (quoting *Fabi Constr. Co. v. Sec’y of Lab.*, 508 F.3d 1077, 1081 (D.C. Cir. 2007)).

¹⁰¹ *Id.* (quoting *Fabi Constr. Co. v. Sec’y of Lab.*, 508 F.3d 1077, 1081 (D.C. Cir. 2007)).

¹⁰² *Id.* (quoting H.R. REP. NO. 911291, at 21–22 (1970)).

¹⁰³ See *Healthcare*, OSHA, <https://www.osha.gov/healthcare> [<https://perma.cc/Z6WY-4N5U>] (delineating “healthcare” as one of the main “[s]afety and [h]ealth [t]opics” over which OSHA continues to exercise its authority); see also *Healthcare Standards*, OSHA, <https://www.osha.gov/healthcare/standards> [<https://perma.cc/5YDD-53X7>] (enumerating OSHA healthcare standards codified at 29 C.F.R. § 1910).

¹⁰⁴ See, e.g., Scott Burris & Jamie Crabtree, *OSHA in a Health Care Context*, TUBERCULOSIS IN THE WORKPLACE (2001) (highlighting the fact that Courts have been “highly deferential” to OSHA in determining the “most protective standard” necessary to mitigate the risk of occupational exposure to tuberculosis pursuant to its statutory authority to control exposure to toxic substances).

As recently as January 2022, in *National Federation of Independent Business v. Department of Labor*, revisited at length below, SCOTUS reaffirmed OSHA's authority to adopt safety and health standards to counteract “*special danger[s]*” posed by “the *particular features* of an employee’s job or workplace,” noting that “targeted regulations are plainly permissible.”¹⁰⁵ Notwithstanding this dicta, SCOTUS ultimately held that OSHA overstepped its administrative authority when it sought to establish an emergency standard related to COVID-19 that would affect virtually *all* workplaces indiscriminate of their “particular features.”¹⁰⁶ In a related yet notably distinguishable case, *Biden v. Missouri*, SCOTUS held that the Department of Health and Human Services (“DHHS”) Center for Medicare and Medicaid Services (“CMS”) had the authority to mandate a similar COVID-19 protocol for its facility beneficiaries.¹⁰⁷ Taken together, these cases allow for the inference that OSHA would have survived judicial scrutiny had it sought to establish the emergency standard questioned in *National Federation of Independent Business v. Department of Labor* specifically in the healthcare workplace. Stated alternatively, OSHA could have exercised its authority to develop and promulgate a standard intended to mitigate the spread of COVID-19 amongst healthcare workers and expected that SCOTUS would have affirmed such an act—reemphasizing the great deference federal courts provide to OSHA in its efforts to mitigate the particular safety and health hazards the healthcare workplace poses to its workers.¹⁰⁸

IV. OSHA HAS THE AUTHORITY TO REGULATE MEDICAL RESIDENT DUTY HOURS

A. *Are Medical Residents Statutory Employees?*

Any employment law analysis begins with consideration of worker classification to determine if the worker at issue is covered by the statutory scheme in question.¹⁰⁹ As noted previously, the OSH Act’s reach is

¹⁰⁵ Nat’l Fed’n of Indep. Bus. v. Dep’t of Lab., 595 U.S. 109, 119 (2022) (emphasis added).

¹⁰⁶ *Id.* at 117–19.

¹⁰⁷ *Biden v. Missouri*, 142 S. Ct. 647, 650 (2022) (upholding a CMS mandate requiring facilities receiving CMS funds to require staff, without medical or religious exemptions, to be vaccinated for COVID-19).

¹⁰⁸ See, e.g., Burris & Crabtree, *supra* note 104.

¹⁰⁹ See, e.g., *How to Apply the Common Law Control Test in Determining an Employer/Employee Relationship*, SOC. SEC. ADMIN., https://www.ssa.gov/section218training/advanced_course_10.htm#1 [<https://perma.cc/27ZN-3J9B>] (explaining the importance of determining whether an employee-employer relationship exists for the application of Social Security coverage); *Fact Sheet 13: Employment Relationship Under the Fair Labor Standards Act (FLSA)*, U.S. DEP’T OF LAB. WAGE AND HOUR DIV., <https://www.dol.gov/agencies/whd/fact-sheets/13-flsa-employment-relationship> [<https://perma.cc/T9RQ-PJ93>] (revised Mar. 2022) (describing how the Economic Realities Test is applied to determine

intentionally broad, covering non-public employers (except the USPS), not otherwise regulated by other governmental bodies, with at least one employee.¹¹⁰ Under the Act, employees are circularly defined as those employed by employers subject to the Act.¹¹¹ Where employment status is in question, Courts apply the common law agency Right to Control Test to ascertain whether the worker is a statutory employee or an independent contractor—a determination that consequentially triggers (or does not trigger) the statute’s protections.¹¹²

In line with my fellow scholar, W. Paige Hren,¹¹³ I view medical residents as statutory employees for purposes of the OSH Act, though this issue has been hotly debated historically. “In November of 1999 the [NLRB] overturned the 1976 *Cedars-Sinai, St. Clare’s Hospital* precedent that ruled that resident physicians are primarily students rather than employees,” instead, concluding that “[a]mple evidence exists . . . to support [a] finding that . . . resident[s] . . . fall within the broad definition of ‘employee’” for purposes of the NLRA.¹¹⁴ The Board additionally noted that medical residents’ “status as students is not mutually exclusive of a finding that they are employees.”¹¹⁵ The NLRB applies the same test applied under the OSH Act, the Right to Control test, to determine if workers are employees subject to the protections of the NLRA.¹¹⁶ Thus, there is no need to question whether courts applying the same test for purposes of the OSH Act under the same factual circumstances would yield different results—unless, of course, there is some indication that courts are unlikely to adhere to *stare decisis*.

B. How Can OSHA Regulate Medical Resident Duty Hours?

Outside of its authority to issue certain emergency standards, OSHA has two general means of developing and promulgating safety and health standards for covered employers: through (1) the standard development procedure

whether someone is an employee or independent contractor for the purposes of the Fair Labor Standards Act); *Who Is Not Covered by OSHA?*, COMPLIANCY GRP., <https://compliance-group.com/who-is-not-covered-by-osha/> [<https://perma.cc/GV6G-DV2D>] (identifying independent contractors as a group of workers not protected by the OSH Act).

¹¹⁰ See 29 U.S.C. § 652(5).

¹¹¹ 29 U.S.C. § 652(6).

¹¹² See *Standard Interpretations: Information on Temporary Workers, Particularly Those in the Electronic Assembly Industry*, OSHA, <https://www.osha.gov/laws-regs/standardinterpretations/1996-04-30> [<https://perma.cc/EN9E-ADSC>] (“Whether or not exposed persons are employees . . . depends on several factors, the most important of which is who controls the manner in which the employees perform their assigned work.”).

¹¹³ See Hren, *supra* note 23, at 464.

¹¹⁴ See *2010 Petition*, *supra* note 17, at 33.

¹¹⁵ *Id.*

¹¹⁶ See JON O. SHIMBAKURO, CONG. RSCH. SERV., R46765, WORKER CLASSIFICATION: EMPLOYEE STATUS UNDER THE NATIONAL LABOR RELATIONS ACT, THE FAIR LABOR STANDARDS ACT, AND THE ABC TEST 1, 9, 20 (2021).

typical of administrative agencies and (2) enforcement actions based on alleged violations of the General Duty Clause.¹¹⁷ The advantage of proceeding through the standard development procedure typical of administrative agencies is that the standard ultimately adopted will apply across the profession at issue, that is, to all employers across the field operating in the same or similar fashion. In enforcement actions under the General Duty Clause, however, the resulting standards apply only to the specific employer subject to the action, that is, not to other similarly situated employers not subject to the action.¹¹⁸

In the case of medical resident duty hours, OSHA could theoretically address the issue via either mechanism, but the optimal approach would be to proceed through the standard development procedure typical of administrative agencies. That way, the standard OSHA ultimately adopts will reach all teaching institutions sponsoring residency programs. OSHA's regulation of resident duty hours would, in turn, require that the ACGME modify its accreditation standards, including educational expectations, since all residency programs would be required to comply with federal regulation of duty hours. Not doing so would render the illogical result of the ACGME ultimately having to strip the majority of residency-sponsoring institutions of their accreditation for failing to achieve standards it set in line with the duty hour expectations it established prior to federal intervention.

Suppose OSHA, instead, opted to pursue enforcement actions under the General Duty Clause against programs where duty hours had allegedly led to serious physical harm or death, such as in the unfortunately common case of a resident (or residents) suffering chronic fatigue leading to clinical depression and later suicide. The resulting standards would technically only apply to the institutions subject to the action. Those institutions would, of course, be required to comply with the standards, but this could create accreditation issues. If, for example, a residency program is mandated to comply with a sixty-hour work week, with no four-week averaging, it is possible that medical residents at the institution may not be able to achieve the ACGME's minimum educational requirements putting the residency program's accreditation in jeopardy. While there is minimal doubt that OSHA would be able to meet its burden to exercise its authority under the General Duty Clause against residency programs where physician suicide has occurred in the

¹¹⁷ See *OSHA Standards Development*, *supra* note 92; see also Alan Ferguson, *OSHA's General Duty Clause*, SAFETY+HEALTH (Dec. 20, 2019), <https://www.safetyandhealthmagazine.com/articles/19258-oshas-general-duty-clause> [<https://perma.cc/CAV3-7MSK>].

¹¹⁸ See John Ho, *Can OSHA Issue Citations for General-Duty Violations?*, SOC'Y FOR HUM. RESOURCE MGMT. (Apr. 26, 2019), <https://www.shrm.org/resourcesandtools/legal-and-compliance/employment-law/pages/can-osha-issue-citations-for-general-duty-violations.aspx> [<https://perma.cc/9T5V-B6EF>] ("Employers can be cited for violating the . . . general-duty clause if they fail to take reasonable steps to prevent or fix a serious hazard in their workplace.").

context of excessive duty hours (a hazard recognized by the ACGME itself),¹¹⁹ the result of such action would be nowhere as sweeping as necessary to address the systemic issue while also creating unintended, negative consequences for the targeted institution(s) and the residents they employ.

Though OSHA undoubtedly has the authority to regulate resident duty hours based on the well documented safety and health hazards excessive duty hours pose to medical residents, exercising that authority without judicial scrutiny under current political circumstances, in the context of OSHA's two past refusals to so intervene, would be a feat of epic proportions.

V. THE APPARENT FUTILITY OF POTENTIALLY SWEEPING OSHA ACTION

A. *A Modern Threat: SCOTUS' "Major Questions Doctrine"*

Because the judiciary has repetitiously reaffirmed OSHA's authority to develop and promulgate standards to mitigate safety and health hazards specific to the healthcare workplace, it would appear to follow that OSHA should encounter minimal resistance for exercising that authority to regulate medical resident duty hours.¹²⁰ That idealistic conclusion, however, rests on the assumption that medical residents are engaged in the typical employer-employee relationship with their healthcare employer when, in reality, their status in the workplace is anything but typical.

Recall that residents' employment is characterized by their concomitant roles as employees of a healthcare facility and graduate medical trainees of a residency program subject to ACGME oversight. Theoretically, this duality should not matter in determining whether OSHA has authority to develop and promulgate a resident duty hour standard to address the well documented safety and health hazards that excessive duty hours pose to residents who are, as noted, first and foremost, employees of their healthcare facility. Unfortunately, current political circumstances and SCOTUS' newly minted conservative supermajority have cast doubt on longstanding deference to administrative agencies—including the Department of Labor and thereby OSHA. What was once an all-but-assured authority may now be in question, in large part due to the dichotomous status of medical residents as employees and trainees and how regulation of residents as employees may have serious ramifications on their training, not to mention the healthcare system at large. It is precisely through this lens that I question whether any present-day OSHA action to restrict resident duty hours could pass SCOTUS scrutiny and, more

¹¹⁹ See, e.g., *ACGME Common Program Requirements (Residency)*, *supra* note 19, at 45–46 (“The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include: attention to resident . . . burnout, [and] depression.”).

¹²⁰ See, e.g., *Burris & Crabtree*, *supra* note 104, at 284 (“Courts will generally defer to OSHA's decision to define an adverse health condition a *material impairment*.”).

specifically, whether, in consideration of such ramifications, SCOTUS would render such an act a “major question.”

The “major questions doctrine” is not necessarily a *new* theory, finding its roots in the “nondelegation doctrine,” which SCOTUS has invoked historically to prevent “Congress from intentionally delegating its legislative powers to unelected officials,” namely those staffing administrative agencies.¹²¹ The doctrine has more recently taken on new life amidst the clear Conservative supermajority of the modern-day Supreme Court.¹²²

Conservatives, historically, have been skeptical of administrative action, believing that congressional delegation to administrative bodies, in many cases, allows elected officials to avoid accountability for “unpopular actions,” thus “dash[ing] the whole scheme’ of our Constitution.”¹²³ While SCOTUS has yet to abrogate *Chevron* deference¹²⁴—the lens through which it reviews commonplace administrative actions against their statutory backdrops—its recent application of the “major questions doctrine” to curb what it perceives to be large-scale administrative action with “vast economic and political significance” moves us closer to that result.¹²⁵ SCOTUS applied the “major questions doctrine” in two recent, high-profile cases: (1) *National Federation of Independent Business v. Department of Labor*¹²⁶ and (2) *West Virginia v. Environmental Protection Agency*¹²⁷—in both cases concluding that the administrative agency at issue acted beyond its statutory authority.¹²⁸

¹²¹ See *Nat’l Fed’n of Indep. Bus. v. Dep’t of Lab.*, 595 U.S. 109, 124 (2022) (Gorsuch, J., concurring); see also *Biden v. Nebraska*, 143 S. Ct. 2355, 2374 (2023) (reiterating that, despite the “relatively recent” use of the “major questions ‘label,’” the underlying doctrine has been applied for “decades” (quoting *West Virginia v. Env’t Prot. Agency*, 142 S. Ct. 2587, 2609 (2022))).

¹²² See, e.g., *Biden*, 143 S. Ct. at 2374; *Nat’l Fed’n of Indep. Bus.*, 595 U.S. at 122–25 (Gorsuch, J., concurring); *West Virginia v. Env’t Prot. Agency*, 142 S. Ct. 2587, 2595 (2022).

¹²³ *Nat’l Fed’n of Indep. Bus.*, 595 U.S. at 124–25 (Gorsuch, J., concurring) (quoting Ronald A. Cass, *Delegation Reconsidered: A Delegation Doctrine for the Modern Administrative State*, 40 HARV. J. L. & PUB. POL’Y 147, 154 (2017); *Dep’t of Transp. v. Ass’n of Am. R.Rs.*, 575 U.S. 43, 61 (2015) (Alito, J., concurring)).

¹²⁴ See Richard J. Pierce, Jr., *Is Chevron Deference Still Alive?*, REGUL. REV. (July 14, 2022), <https://www.theregreview.org/2022/07/14/pierce-chevron-deference/> [<https://perma.cc/3CF9-Q3EK>].

¹²⁵ *Nat’l Fed’n of Indep. Bus.*, 595 U.S. at 122 (Gorsuch, J., concurring) (quoting *Ala. Ass’n of Realtors v. Dep’t of Health & Hum. Servs.*, 141 S. Ct. 2485, 2489 (2021)).

¹²⁶ *Id.* at 125–26.

¹²⁷ *Env’t Prot. Agency*, 142 S. Ct. at 2614.

¹²⁸ See Mary-Christine (“M.C.”) Sungaila, *Administrative Law After the 2021 U.S. Supreme Court Term: Climate Change, Immigration, and Separation of Powers*, 64 ORANGE CNTY. LAW. 21, 23 (2022) (acknowledging that such decisions “herald a new era on the Court in which the exercise of administrative power will be closely scrutinized”). During its most recent session, SCOTUS again invoked the “major questions doctrine” to restrain the authority of the Secretary of Education who sought to invoke the HEROES Act to forgive student loans amidst the then-ongoing COVID-19 national emergency. *Biden v. Nebraska*, 143 S. Ct. 2355, 2373–74 (2023).

In *National Federation of Independent Business*, SCOTUS reviewed OSHA’s development of an emergency rule “requiring all employers with at least 100 employees ‘to ensure their workforces are fully vaccinated or show a negative [COVID-19] test at least once a week.’”¹²⁹ This emergency rule, had it gone into effect, would have affected nearly 84 million employees—many of whom were no more susceptible to the contraction of COVID-19 in the workplace than outside of it.¹³⁰ While SCOTUS reaffirmed OSHA’s statutory authority to protect the safety and health of employees in the *workplace*, it perceived this action to far surpass an “everyday exercise of federal power.”¹³¹ SCOTUS made clear that Congress must “speak clearly when authorizing an agency to exercise powers of vast economic and political significance.”¹³² Here, the OSH Act authorized OSHA “to set *workplace* safety standards, not broad public health measures.”¹³³ Had OSHA limited its emergency standard to those workplaces where the risk of contraction of COVID-19 was a “special danger” posed by the nature of the workplace and/or employees’ jobs, such a standard would have been an “*occupational* safety or health standard” rather than a “public health measure.”¹³⁴

In *Environmental Protection Agency*, SCOTUS reviewed the Environmental Protection Agency’s (“EPA”) exercise of its purported authority under Section 111(d) of the Clean Air Act to “devise carbon emissions caps based on a generation shifting approach.”¹³⁵ Invoking the “major questions doctrine,” SCOTUS held that the EPA had overstepped its authority in so acting because Section 111(d) did not provide “a clear delegation” from Congress to enact a regulatory system based on carbon dioxide emission caps that would require a “transition away from the use of coal to generate electricity.”¹³⁶ The Court continued that “[a] decision of such magnitude and consequence rests with Congress itself, or an agency acting pursuant to a clear delegation from that representative body.”¹³⁷ In so holding, the Court also referenced the fact that Congress had previously tried and failed to pass such a measure—lending to its conclusion that such transformative regulation was clearly within Congress’, and not the administrative agency’s, immediate purview.¹³⁸

¹²⁹ *Nat’l Fed’n of Indep. Bus.*, 595 U.S. at 115 (quoting Remarks on the COVID-19 Response and National Vaccination Efforts, 2021 DAILY COMP. PRES. DOC. 775, 2 (2021)).

¹³⁰ *Id.*

¹³¹ *Id.* at 114, 117 (quoting *In re MCP No. 165 v. United States Dep’t of Lab.*, 20 F.4th 264, 272 (2021) (Sutton, C. J., dissenting)).

¹³² *Id.* at 117 (quoting *Alabama Ass’n. of Realtors v. Dep’t. of Health & Hum. Servs.*, 141 S. Ct. 2485, 2489 (2021)).

¹³³ *Id.*

¹³⁴ *Id.* at 119.

¹³⁵ *West Virginia v. Env’t Prot. Agency*, 142 S. Ct. 2587, 2612–14 (2022).

¹³⁶ *Id.* at 2614–16.

¹³⁷ *Id.* at 2616.

¹³⁸ *Id.* at 2610.

While SCOTUS would have us believe otherwise, the “major questions doctrine” is simply not well fleshed out. SCOTUS provides no clear test to determine when an administrative action rises to the level of a measure of “vast economic and political significance” to trigger the requirement of a “clear delegation” from Congress to so act.¹³⁹ Thus, we must rely on the factual circumstances, and the Court’s related reasoning, underlying the aforementioned cases to draw a reasonable conclusion as to the instant question of whether OSHA’s regulation of medical resident duty hours would survive “major questions doctrine” scrutiny.

At first glance, it is easy to argue that OSHA regulation of resident duty hours is in no way analogous to the *sweeping* measures SCOTUS scrutinized in *National Federation of Independent Business* or *Environmental Protection Agency*. There is no apparent, hyper-polarizing political question underlying the proposed action, as there was in *Environmental Protection Agency*, nor does such action have the potential to reach millions of workers across countless industries indiscriminate of individual workplace conditions, as was the case in *National Federation of Independent Business*. Rather, OSHA’s regulation of resident duty hours would be *targeted* to a specific class of protected workers—medical residents—based on well-documented and oft recognized statistics linking severe, if not life threatening, safety and health hazards—including major depression and suicidality—to the *peculiarly* excessive duty hours medical residents face. Such “targeted” action aimed at a “peculiar” safety and health hazard specific to the resident (healthcare) workplace should fit comfortably within the authority present-day SCOTUS just recently reaffirmed in *National Federation of Independent Business*, but there is yet another “major questions” variable at play: the economic significance of such regulation.

There is, in fact, a strong argument that OSHA regulating medical resident duty hours could rise to the level of *vast* economic significance necessary for congressional action or a clear delegation of power to OSHA to so regulate (i.e., making it a “major question”). Though OSHA’s action would technically only reach approximately 160,000 employees—a minuscule number compared to the 84 million that would have been subject to OSHA’s emergency COVID-19 vaccine mandate—the economic impact on the healthcare industry resulting from that action would undoubtedly be substantial. One need look no further than the repercussions of restrictions on resident duty hours on international healthcare care systems to ascertain the enormity of the

¹³⁹ See *Biden v. Nebraska*, 143 S. Ct. 2355, 2374 (2023). Complicating matters further, the Court’s self-professed textualists apparently disagree as to what constitutes such a “clear delegation.” See, e.g., *id.* at 2378 (Barrett, J., concurring) (indicating her belief, contrary to strict textualism, that a statute must be interpreted “in context . . . not . . . exclusively ‘within [its] four corners.’”) (quoting John F. Manning, *The Absurdity Doctrine*, 116 HARV. L. REV. 2387, 2456 (2003)).

effect similar restrictions would have domestically.¹⁴⁰ Hospitals would be forced to either hire additional medical residents without the expectation of CMS reimbursement (something that would require congressional action) or hire additional, fully licensed medical staff to fill gaps in patient care.¹⁴¹ Each additional staff member may cost anywhere from \$60,000 to \$300,000.¹⁴² Even the addition of two staff members per institution to compensate for the hours no longer feasibly staffed by the preexisting medical resident pool would result in millions of dollars in additional healthcare costs in a system that already spends more per capita on healthcare than any other country.¹⁴³

Of course, certain healthcare facilities could elect not to add additional staff to offset the loss in resident staffing, but such a decision could have the unintended consequence of similarly causing an exponential rise in healthcare costs by crippling an already strained system.¹⁴⁴ A failure to compensate for gaps in medical resident coverage without a proportional reduction in patient capacity could leave the remaining healthcare workers at the affected facility with the burden of caring for that many more patients with that much less time, let alone stamina, to do so, leading inevitably to increased workplace injury, medical error, and burnout—all significant contributors to systemic healthcare costs.¹⁴⁵ Related are the economic concerns derived in the ostensibly foreseeable, deleterious effects of restricted duty hours on resident training.¹⁴⁶ The argument would be that more poorly trained physicians (i.e. those with less training hours in residency) will ultimately enter the workforce, which could lead to increased malpractice—another significant contributor to healthcare costs.¹⁴⁷

¹⁴⁰ Cf. CHERYL ULMER ET AL., RESIDENT DUTY HOURS: ENHANCING SLEEP, SUPERVISION, AND SAFETY 339–42 (2009).

¹⁴¹ *Id.* at 298–99, 350, 357.

¹⁴² See Justin Nabity, *Residency Salary Guide for New Physicians*, PHYSICIANS THRIVE, <https://physiciansthrive.com/physician-compensation/residency-salary/> [https://perma.cc/KH26-R6KS] (June 1, 2022) (highlighting that the average medical resident salary in 2021 was \$64,000 per year while the average salary for a fully licensed physician in 2020 ranged from \$243,000 for primary care physicians to \$346,000 per year for specialists).

¹⁴³ See *How Does the U.S. Healthcare System Compare to Other Countries?*, PETER G. PETERSON FOUND. (July 12, 2023), <https://www.pgpf.org/blog/2022/07/how-does-the-us-healthcare-system-compare-to-other-countries> [https://perma.cc/5A96-4BYM].

¹⁴⁴ See Russel Hicks, *The Hidden Cost of Being Understaffed in Healthcare*, ELITE365 HEALTHCARE WORKFORCE SOLS. (Apr. 27, 2023), <https://elite365.com/insights/the-hidden-cost-of-being-understaffed-in-healthcare/> [https://perma.cc/H6XU-Y23X] (“[T]he worsening clinical labor shortage is a significant contributor to our projected increase in healthcare costs . . .”).

¹⁴⁵ See U.S. SURGEON GEN., ADDRESSING HEALTH WORKER BURNOUT: THE U.S. SURGEON GENERAL’S ADVISORY ON BUILDING A THRIVING HEALTH WORKFORCE 9 (2022).

¹⁴⁶ See CHERYL ULMER ET AL., *supra* note 140, at 351–52.

¹⁴⁷ See Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFFS. 1569, 1574 (2010) (estimating the cost of the “medical liability system” in 2008 to be 55.6 billion dollars, “approximately 2.4 percent of total national health care spending”).

A final caveat to consider in the overall calculus is the potential significance of Congress's prior failed attempt to pass legislation to regulate medical resident duty hours.¹⁴⁸ Like the situation in *Environmental Protection Agency*, Congress has, at least on one occasion, attempted to pass such legislation; that effort similarly failed.¹⁴⁹ Evidence that Congress has previously attempted to act and failed in a manner now pursued by an administrative agency without clear delegation indicates to SCOTUS that the desired measure may constitute a "major question."¹⁵⁰

Though regulation of medical resident duty hours does not rise to the level of vast political significance seen in *National Federation of Independent Business* or *Environmental Protection Agency*, the potential economic significance of such an action in the context of at least one past failed attempt by Congress to so act makes it more likely than not that SCOTUS would likely deem any OSHA action to regulate resident duty hours a "major question," and thus an unconstitutional overreach of its express statutory authority.

B. Another Wrinkle: Justice Kavanaugh's Dissent in Seaworld of Florida, LLC v. Perez

Should OSHA's regulation of resident duty hours survive "major question" scrutiny, there are, of course, additional challenges that such an exercise of its authority may face from the present-day SCOTUS conservative supermajority. One need look no further than then-Judge, now Justice, Kavanaugh's dissent in *Seaworld of Florida, LLC v. Perez* for insight into the realm of theoretical, conservative justice attacks on such administrative action.¹⁵¹

In *Seaworld*, the Secretary of Labor cited SeaWorld of Florida for a violation of the General Duty Clause after whale trainer and employee, Dawn Brancheau, was killed by a killer whale, Tilikum, midperformance.¹⁵² Following Brancheau's death, the Secretary of Labor issued a citation alleging that SeaWorld had "willful[ly]" violated the General Duty Clause by exposing its animal trainers "to the recognized hazards of drowning or injury when

¹⁴⁸ See AM. MED. STUDENT ASS'N, *supra* note 57; see also CHERYL ULMER ET AL, *supra* note 140, at 50.

¹⁴⁹ *West Virginia v. Env't Prot. Agency*, 142 S.Ct. 2587, 2605 (2022). See AM. MED. STUD. ASS'N, *supra* note 57.

¹⁵⁰ *Biden v. Nebraska*, 143 S.Ct. 2355, 2373 (2023) (referencing "[m]ore than 80 student loan forgiveness bills" that Congress considered and failed to enact prior to the Secretary of Education's attempt to forgive student loans) (quoting Mark Kantrowitz, *Year in Review: Student Loan Forgiveness Legislation*, FORBES (Dec. 24, 2020), <https://www.forbes.com/sites/markkantrowitz/2020/12/24/year-in-review-student-loan-forgiveness-legislation/?sh=60c303997e9a> [<https://perma.cc/GCM2-55Q8>]).

¹⁵¹ *SeaWorld of Fla. v. Perez*, 748 F.3d 1202, 1216 (D.C. Cir. 2014).

¹⁵² *Id.* at 1205.

working with killer whales during performances.”¹⁵³ The D.C. Circuit majority affirmed the Secretary of Labor’s citation of SeaWorld for a General Duty Clause violation concluding that (1) working with killer whales presented a safety hazard; (2) SeaWorld knew of the safety hazard as reflected by their public statements and the various safety measures they implemented both pre- and post-whale trainer, Dawn Brancheau’s, death; (3) Brancheau was killed while working with a killer whale; and (4) SeaWorld’s safety measures were inadequate to avoid the safety hazard posed by working with killer whales.¹⁵⁴

Then Circuit Judge Kavanaugh took a very different approach from that of the majority, instead, highlighting his view that certain professions, namely “sports events and entertainment shows,” are innately dangerous and that “participants in those activities want to take part, sometimes even to make a career of it, despite and occasionally because of the known risk of serious injury.”¹⁵⁵ In his view, OSHA should either exercise its authority to regulate all such innately dangerous workplaces or, optimally, as it had historically, defer to the various bodies overseeing those workplaces since they are substantially better positioned to mitigate safety and health hazards posed by their unique working conditions.¹⁵⁶ In contrast to the majority, he would have held that OSHA overstepped its authority under the General Duty Clause because it departed from “longstanding administrative precedent” in which it had not elected to regulate “sports events or entertainment shows . . . without acknowledgment or explanation” as to why this was the right time to do so.¹⁵⁷

Justice Kavanaugh’s dissent is significant not only because of his reliance on examining present-day administrative action through a historical lens but also because it appears to breathe new life into the theory of assumption of the risk.¹⁵⁸ He reflects on his belief that employees in sports and entertainment choose to pursue employment in those professions despite, and sometimes “because of,” their knowledge of the inherent risks of the workplaces

¹⁵³ *Id.*

¹⁵⁴ *Id.* at 1208–15.

¹⁵⁵ *Id.* at 1216.

¹⁵⁶ *Id.* at 1218.

¹⁵⁷ *Id.*

¹⁵⁸ Justice Kavanaugh’s dissent in *Sea World* ominously harkens back to a different era, one defined by employees’ right to contract for employment of their choosing with no more than nominal government intervention or oversight—a so called *laissez-faire* approach. *See, e.g.,* *Lochner v. New York*, 198 U.S. 45, 64–65 (1905) (holding that a New York state law setting maximum work hours for bakers violated the bakers’ right to freedom of contract). During this period, infamously referred to as the *Lochner* era, courts brandished their respect for so-called “freedom of contract,” making clear that private parties could contract as they so desired and, in contracting, absorb whatever risk thereby flowed to them. In the employment context, this meant that an employee assumed the risk that flowed from whatever employment for which they contracted.

associated with those professions.¹⁵⁹ Though one may interpret Justice Kavanaugh's opinion on its face as limited to his beliefs about employment in the sports and entertainment contexts, his theories can easily extend to other non-sports or entertainment workplaces ripe with their own inherent safety and health risks well known to prospective employees—especially if such workplaces had previously been free of OSHA regulation.

An obvious reason Justice Kavanaugh responded as he did to OSHA's enforcement action against SeaWorld was because, to that point, despite its knowledge of inherent safety and health concerns, OSHA had been completely hands-off in the sports and entertainment realms.¹⁶⁰ Justice Kavanaugh pointed out that OSHA had, instead, historically deferred to the private bodies overseeing those fields to consider and address the safety and health of their employees. Despite Brancheau's death, Justice Kavanaugh was simply not convinced that OSHA had a sufficient basis to warrant such a stark shift in its exercise of authority over SeaWorld's operation. In a similar fashion, OSHA has notoriously declined, on at least two occasions, to exercise its authority to regulate resident duty hours despite its knowledge of the severe safety and health risks that excessive duty hours pose for medical residents.¹⁶¹ On those occasions, just as it had with SeaWorld prior to Brancheau's death, OSHA deferred to the ACGME based on its stance that the ACGME was in a better position to balance the safety and health of medical residents with their training requirements.¹⁶² OSHA's past refusals to regulate resident duty hours without a showing of significant change in the resident workplace to substantiate a reversal of its position could render any future OSHA intervention in this realm administrative overreach in the eyes of the present-day SCOTUS conservative supermajority.

Justice Kavanaugh's invocation of the *assumption of the risk* doctrine—albeit not expressly by name—may also apply in the residency context. While healthcare workplaces are by no means *inherently dangerous* in the same way workplaces in the sports and entertainment industries are, there is an argument to be made that medical residents *know* that they will be subject to often excessive duty hours during their residency tenure and, as a result, assume the risk of the repercussions of such a workplace condition when they choose to pursue graduate medical education despite this knowledge.

The proposed OSHA action can, of course, be distinguished from *SeaWorld*—though not dispositively. Unlike in the sports and entertainment industries, OSHA has historically regulated healthcare workplaces, including hospitals sponsoring residency programs, which, at least superficially, lends support for OSHA extending that authority to regulate resident duty hours in

¹⁵⁹ *Sea World*, 748 F.3d at 1216–17.

¹⁶⁰ *Id.* at 1218.

¹⁶¹ See *OSHA Should Use Its Existing Authority*, *supra* note 16.

¹⁶² See *id.* (“OSHA declined to take [medical residents] under its purview, leaving regulation of their hours to the [ACGME].”).

the *same* workplace.¹⁶³ An issue arises, however, when one considers that OSHA has expressly declined to regulate healthcare workplace conditions inextricably linked to medical resident training—thus obviating its recognition of the unique challenge that arises in protecting the safety and health of the medical resident who serves the dual role of employee and trainee.¹⁶⁴ OSHA's past deference to the ACGME to balance the often-conflicting needs of the medical resident employee-trainee essentially divides the general healthcare workplace into two overlapping spaces: the hospital, over which it has authority, and the residency, over which it chooses not to. Without significant alteration in residency workplace conditions creating previously unrecognized safety and health hazards, SCOTUS would inevitably question why OSHA now feels it is the appropriate time to exercise the authority it has, to this point, failed to exercise for well over two decades. Would a simple acknowledgment of the ongoing resident suicide epidemic and its ties to excessive duty hours be sufficient to overcome this inquiry? Probably not.

VI. THE SILVER LINING OF LOSS: WHY OSHA SHOULD STILL INTERVENE

Considering the foreseeable futility of OSHA opting to regulate resident duty hours under modern-day SCOTUS scrutiny, it would be reasonable to question whether there would be any real value in OSHA pursuing this course of action. After all, why would an administrative agency take substantial steps—not to mention invest considerable resources—to act if their intended action is all but guaranteed to fail? Enter the concept of “Movement Lawyering”¹⁶⁵ and the related theory of “Winning Through Losing,”¹⁶⁶ which collectively tell us that there is, in fact, long-term value in short-term loss.

From a certain perspective, a loss can be nothing more than a loss. Accepting this conclusion, however, fails to give credence to any number of successful social movements that have indisputably unlocked the inherent power of discrete, incremental losses to achieve their desired ends.¹⁶⁷ Losses,

¹⁶³ See *Healthcare*, OSHA, <https://www.osha.gov/healthcare> [<https://perma.cc/Z6WY-4NSU>] (describing known safety and health conditions in the healthcare workplace); see also *Standards*, OSHA, <https://www.osha.gov/healthcare/standards> [<https://perma.cc/5YD-D-53X7>] (providing a list of “frequently cited” and “[h]ighlighted” standards regulating the healthcare workplace).

¹⁶⁴ See *OSHA Should Use Its Existing Authority*, *supra* note 16.

¹⁶⁵ See Scott L. Cummings, *Movement Lawyering*, 27 IND. J. GLOB. LEGAL STUD. 87, 87 (2020) (highlighting “the rise of ‘movement lawyering’ as an alternative model of public interest advocacy”); see also Scott L. Cummings & Doug Smith, *Policy by the People, for the People: Designing Responsive Regulation and Building Democratic Power*, 90 FORDHAM L. REV. 2025, 2045 (2022) (exploring how “[b]ottom-up policy campaigns,” which leverage the “expertise and personal stories of people most impacted by the policy in question,” can be used to inspire policy change).

¹⁶⁶ See Douglas NeJaime, *Winning Through Losing*, 96 IOWA L. REV. 941, 1011–12 (2011) (exploring the myriad ways in which litigation losses can catalyze social movements).

¹⁶⁷ *Id.* at 970 (discussing the LGBT-rights and Christian Rights movements).

especially on a large scale (and even more so in the public eye), can have considerable ripple effects across a multitude of interrelated systems.¹⁶⁸ Loss may inspire concerted activity—that is, the organization of groups around a common goal.¹⁶⁹ Loss may incentivize those personally affected by a questionable policy to flood the public domain with their own experiences.¹⁷⁰ Loss may drive external interest groups to not only fund organizations leading the charge but also to advocate, themselves, for the desired change.¹⁷¹ Loss, then, for a movement's sake, becomes anything but a loss; rather, it fosters further opportunity for long-term gain.

To be frank, counteracting the plight of medical residents is not necessarily a traditional “social movement,” but, like any social movement, it still finds its roots in the human experience. For that very reason, it exemplifies the type of movement that may be acutely susceptible to short-term losses but may inevitably hone the momentum from each of those losses to ultimately achieve the desired ends.¹⁷² History, in fact, fully supports this assertion. Consider what I refer to as the “systematic pressure campaign” between 2001 and 2002 involving Public Citizen, Congress, and various medical organizations that ultimately led the ACGME, in 2003, to adopt its most restrictive duty hour standards to date. This was a movement that suffered discrete losses—most notably, OSHA’s declining to exercise its authority to regulate resident duty hours and Congress’s failure to pass legislation that sought to restrict resident duty hours while further funding graduate medical education—but ultimately, with considerable public outcry, achieved some semblance of the desired result. That is, the ACGME, for the first time, formally adopted duty hour standards for medical residents. Amidst this movement, none of the individual efforts by the interested actors were successful on their own terms. Instead, what was successful was the amalgamation of their respective efforts, which collectively inspired public attention to the issue, created a threat of federal intervention in graduate medical education, and ultimately forced the ACGME’s hand.

Today, we are at a similar precipice to that which inspired the 2001–2002 movement to regulate resident duty hours. Despite the ACGME’s ostensible efforts to mitigate the safety and health risks associated with working excessive hours, residents continue to suffer major depression and suicidality at alarmingly high rates that demand further intervention. Thus, I call on OSHA to formally change its position on regulating resident duty hours and to begin the standard development process—or more aggressively pursue enforcement

¹⁶⁸ *Id.* at 969.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² See Cummings & Smith, *supra* note 165, at 2045 (highlighting the power of focusing on the personal to shift “political dynamics” and pressuring “politicians” and other stakeholders “to support movement demands”).

actions against certain sponsoring institutions under the General Duty Clause—in hopes of igniting a renewed social movement. My hope would be that such action, though foreseeably futile alone, would trigger just the ripple effect needed to, once again, force the ACGME's hand in further restricting residency duty hours.

CONCLUSION

It goes without saying that we are still living amidst a medical resident suicide epidemic driven, not simply by the stress of medicine, but more so by the inhumane working conditions under which residents are required to work pursuant to the Common Standards promulgated by the ACGME. Research has shown a significant relationship between the excessive work hours medical residents work, chronic fatigue, and the development of diagnostic mental illness—most commonly, clinical depression—which subjects them to significantly higher rates of suicidality than non-medical resident members of the general population. Though OSHA has rejected two previous petitions to regulate resident duty hours despite well-established authority to do so under the OSH Act, there is reason for it to do so now: in hopes of inspiring a renewed social movement, analogous to the 2001–2002 “systematic pressure campaign” that caused the ACGME to regulate resident duty hours formally for the first time, to further restrict residency duty hours and thereby curb the ongoing resident suicide epidemic. Inherent in this objective is the understanding that any standard OSHA theoretically develops will likely be rendered unconstitutional under modern-day SCOTUS scrutiny, but it is just that ostensible loss, on such a large, public scale, that could have the power to ignite the flame of social change necessary to, once again, force the ACGME's hand. There is no time better than the present to take action to seek justice for those who have already, and those who may be on the verge of, falling victim to this endlessly oppressive system. Indeed, OSHA harbors the precise power necessary to set the wheels of change in motion.