

PART I

EXEMPT ORGANIZATIONS TECHNICAL TOPICS

A. MEDICAL RESIDENTS REFUND CLAIMS TRAINING

by
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Introduction/Overview

The purpose of this training guide is to provide guidance to TEGE and IRS exam personnel in handling FICA refund claims filed with respect to medical residents. This training guide begins with a general description of medical residency programs and the student FICA exception.¹ This guide next explains that whether the student FICA exception applies, or whether a resident is a student within the meaning of the student exclusion under the Social Security Act (the “Act”), is determined with reference to the common law employer. In this regard, these materials discuss many of the relevant facts in identifying the common law employer. Next, this guide discusses the special considerations if the employer is a state or local government entity, including determining whether the residents’ services are covered under an agreement with the Social Security Administration (SSA) to cover state and local government employees under social security (a “§ 218 agreement”). If residents’ services performed for a state or local government entity are not covered under a state’s § 218 agreement, or if the common law employer is a nongovernmental employer, then it must be determined whether the requirements under § 3121 (b)(10) (“the student FICA exception”) have been met, including the employer status and student status requirements. Finally, these training materials discuss the refund claim procedures that taxpayers must follow in order to receive a refund of employment taxes.

**The Student
FICA
Exception
Under
§ 3121(b)(10)**

Sections 3101-3126 of the Internal Revenue Code impose Federal Insurance Contribution Act (FICA) taxes on the wages of employees. FICA taxes consist of old-age, survivors, disability insurance portion (usually called social security tax) and a Medicare portion.

Section 3121 (b)(10) of the Code excepts from the definition of employment for FICA purposes services performed in the employ of a school, college, or university (“S/C/U”) (whether or not that organization is exempt from income tax), or an affiliated organization that satisfies section 509(a)(3) of the Code in relation to the S/C/U (“related § 509(a)(3) organization”) if the service is performed by a student who is enrolled and regularly attending classes at that S/C/U. Thus, the student FICA exception applies to services only if both the “employer status” and “student status” requirements are met.

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Introduction/Overview, Continued

**The Student
FICA
Exception
Under
§ 3121(b)(10)
(continued)**

The employer status requirement means that the employer for whom the employee performs services (the common law employer) must be either a S/C/U or a related § 509(a)(3) organization. The student status requirement means that the employee must have the status of a student at the S/C/U. If either the student status or employer status requirement is not met, the student FICA exception does not apply, and the resident would be covered under the FICA unless the resident's services qualify for some other exception.² See Exhibit 1 for the steps involved in analyzing these issues.

Notes

1. FICA refund claims have been filed also with respect to residents in other health care fields, such as dentistry. The same legal analysis applies in those cases as in medical resident cases.
 2. For example, if the employer is a state or local government, the resident's services are not covered under a § 218 agreement, and the resident is a participant in a retirement system under section 3121 (b)(7)(F), the resident's services would not be considered employment for FICA purposes. Section 3121 (b)(7)(F) became effective with respect to services performed after July 1, 1991. However, the resident's services would probably be subject to Medicare tax under § 3121 (u)(2).
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Exhibit 1

Medical Residency Programs¹

Overview

A medical residency program prepares a medical doctor (that is, a person who has graduated from medical school and earned a medical degree) for practice in a medical specialty. The medical doctors in a residency program are referred to as “residents.”² Most residents are in residency programs accredited either by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA). These accrediting bodies require that a sponsoring institution abide by detailed program requirements covering all aspects of the training program. The largest number of residency programs are in the areas of family practice, internal medicine, pediatrics, obstetrics/gynecology, radiology, and general surgery.³ The program requirements vary depending upon the type of program.⁴ In completing an accredited program, a resident typically completes the education requirements for certification by a specialty board recognized by the American Board of Medical Specialties (ABMS). The resident is then eligible to take the board examination in a medical specialty area.⁵

Medical Residents

To become a resident, an individual must have graduated from medical school and have passed parts one and two of the U.S. medical licensing exam. The individual is then eligible to receive a temporary license from the appropriate state medical licensing board. The temporary license permits the resident to practice under the auspices of the residency program in which the resident participates. After completing a period of graduate medical education (GME) (typically one year, as determined by the state⁶) and passing part three of the U.S. medical licensing exam, a resident is eligible to become fully licensed to practice medicine. At this point, the resident can legally practice outside the residency program, either by leaving the residency program, or by “moonlighting” while still in the residency program.

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Medical Residency Programs, Continued

Sponsoring and Participating Institutions

GME programs have a “sponsoring institution” and may have other “participating institutions.”⁷ An “institution” is an organization having the primary purpose of providing education or health care services (e.g., a medical school or a hospital).⁸ The sponsoring institution is usually a medical school or a hospital. A hospital that is a sponsoring institution will often have some affiliation with a medical school. The sponsoring institution establishes the residency program and has overall authority and is responsible for the residents’ GME. A sponsoring institution generally sponsors residency programs in several specialty areas. The participating institutions provide additional opportunities to obtain medical experiences within a residency program. Both sponsoring and participating hospitals are commonly referred to as “teaching hospitals.” Although the organization and structure of GME programs vary, see Exhibit 2, Models A – D for diagrams of common structures.

Period of Training

Most accredited training programs require a period of residency of from three to seven years depending upon the specialty area. For example, family practice and internal medicine typically require a 3-year training period, whereas general surgery typically requires a 5-year training program which may be extended one or two years if the resident participates in a subspecialty program.

The duties and responsibilities of a medical resident may change as the training program progresses. Residents take on more responsibility according to their level of education, ability and experience, including supervising the work of more junior residents along with attending physicians.

The Dual Roles of Attending Physicians

Attending physicians generally play two roles with respect to medical residents. First, attending physicians are responsible for supervising resident patient care services. An attending physician must be the physician of record for every patient. In this regard, the attending physician may be acting as an agent of the hospital with respect patient care services depending upon the attending physician’s relationship with the hospital. The relationship with the hospital may be either as an employee or independent contractor. The attending physician may be paid by the hospital or may merely have staff privileges at the hospital.

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Medical Residency Programs, Continued

The Dual Roles of Attending Physicians (continued)

Second, attending physicians also have a duty to the sponsoring institution to train medical residents and monitor their progress. Regardless of whether the sponsoring institution is a medical school or hospital, attending physicians generally hold faculty appointments at the sponsoring institution and are referred to as “faculty.” Attending physicians may or may not be paid by the sponsoring institution for services performed in training residents.

Faculty Practice Plans

The entity responsible for providing patient care services could also be a faculty practice plan affiliated with a university medical school. Medical school faculty, as part of their duties as medical school professors, may treat patients at hospitals affiliated with the medical school under the auspices of a faculty practice plan. Faculty practice plans may or may not be legal entities apart from the medical schools with which they are affiliated. The patient care fees generated by faculty practice plans generally accrue to the affiliated medical school. Medical residents are often involved in patient care services provided by faculty practice plans.

Notes

1. The description of medical residency programs in this memo is based largely upon information in the American Medical Association’s, Graduate Medical Education Directory (2000/2001) (commonly referred to as the “Green Book”).
 2. The term “intern” historically referred to an individual participating in a one-year training program that was a prerequisite to admission into a residency program. Internship programs were discontinued across the country in 1975, and residency programs have since included medical school graduates in their first year of graduate medical education. First year residents are often referred to as interns. Residents may also be referred to as “house staff” or “house officers.”
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Medical Residency Programs, Continued

**Notes
(continued)**

3. The 1998-1999 statistical information in the following chart was obtained from a document published by the American Medical Association entitled Characteristics of Graduate Medical Education Programs and Resident Physicians by Specialty. For these years, the survey states that the number of residents in ACGME-accredited programs was 97,383.

Characteristics of Selected Residency Programs				
Program	Programs	Number of Residents	Avg. No. Residents Per Program	Accredited Length (Years)
Family Practice	502	10,607	21	3
Internal Medicine	410	21,130	52	3
Ob/Gyn	262	4,810	18	4
Pediatrics	209	7,728	37	3
Radiology	198	3,687	18	4
General Surgery	262	7,859	30	5
Thoracic Surgery	90	319	3.5	2

4. We have included as Exhibit 4 at the end of these materials the ACGME program requirements for residencies in internal medicine and radiology. These program requirements as well as the program requirements for all other types of residencies accredited by the ACGME may be found at www.acgme.org.
5. Being eligible to take a board examination or having passed a board examination is often a prerequisite to obtaining staff privileges or participating as a provider in health insurance plans.
6. Nevada requires three years of GME; Connecticut, Michigan, New Hampshire, New Mexico, Pennsylvania, South Dakota, Utah and Washington require two years.
7. The terms “sponsoring institution” and “participating institution” are used by the American Medical Association’s Green Book.
8. For purposes of these training materials, the term “hospital” means any facility that has as its purpose the provision of medical care to patients, including outpatient medical clinics that provide outpatient services.

Exhibit 2 (1 of 4)

Exhibit 2 (2 of 4)

Exhibit 2 (3 of 4)

Exhibit 2 (4 of 4)

Who Is the Employer?

The Student FICA Exception Is Determined with Reference to the Common Law Employer

The first step in determining whether a medical resident is subject to FICA is to determine the entity that is the common law employer of the resident. Section 31.3121 (b)(10)-2(c) of the Employment Tax Regulations provides that “the status of the employee as a student performing the services shall be determined on the basis of the relationship of such employee with the organization for which the services are performed.” Thus, the identity of the common law employer is essential to determining whether the exclusion under § 3121(b)(10) applies because the common law employer must be a S/C/U. Identifying the common law employer is also essential to determining whether the resident is covered by a § 218 agreement (discussed below).

This issue arises because the residency program may include assignments (“rotations”) at institutions other than the sponsoring institution. For example, the sponsoring institution may be a medical school but all clinical aspects of the residency may be performed at participating institutions whose only affiliation with the medical school is by contract (“affiliation agreement”) (see Exhibit 2, Model C). The sponsoring institution may assert that the participating hospital where the services are performed is not the common law employer. Thus, the issue arises whether the sponsoring institution or the hospital where the resident performs services is the resident’s common law employer.¹

Right to Direct and Control

The common law employer is the party that has the right to direct and control the medical resident. Direction and control is the test not just for determining whether the worker is an employee versus independent contractor, but also determines which party is the employer when the worker has a relationship with more than one entity. See the training materials on employee versus independent contractor status. “Independent Contractor or Employee?” Training 3320-102 (Rev. 10-96) TPDS 842381.

Section 3121(d)(2) of the Code provides that the term “employee” means any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee. The question of whether an individual is an employee under the common law rules or an independent contractor is one of fact to be determined after consideration of the facts and the application of the law and regulations in a particular case. Guides for determining the existence of that status are found in three substantially similar sections of the Employment Tax Regulations; namely, sections 31.3121(d)-1, 31.3306(i)-1 and 31.3401(c)-1 relating to the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), and federal income tax withholding, respectively.

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Who Is the Employer?, Continued

Right to Direct and Control (continued)

In describing when an employment relationship exists, § 31.3121(d)-1(c)(2) of the regulations provides,

Generally, such relationship exists when the person for whom the services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. That is, an employee is subject to the will and control of the employer not only as to what shall be done but as to how it shall be done. In this connection, it is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if he or she has the right to do so.

The regulations generally identifying employers speak of them as persons who employ employees (§§ 31.3121(d)2 and 31.3306(a)-1 of the regulations) and as any person for whom services are performed as an employee (§ 31.3401(d)-1 of the regulations).

Sections 3401(d)(1), 3504, 3121(s) Status Not Enough

The fact that the sponsoring institution pays the resident and treats the resident as an employee for payroll purposes does not mean that the resident is the common law employee of the sponsoring institution. The sponsoring institution could instead be the statutory employer (the person having control over the payment of wages) under § 3401(d)(1).² Alternatively, the sponsoring institution may be an agent for purposes of employment tax obligations under § 3504, may be a common paymaster under § 3121(s), or may merely be acting as a common law agent for payroll purposes. Although a statutory employer, agent, or common paymaster (but not a common law agent) is liable for any FICA tax due, whether the student FICA exclusion applies is determined with reference to the common law employer.

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Who Is the Employer?, Continued

Cases Involving Three-Party Relationships

Several cases involving three-party employment arrangements have considered which entity, if any, is the common law employer. In Professional & Executive Leasing, Inc. v. Commissioner, 89 T.C. 225, 232-233 (1987), aff'd, 862 F.2d 751 (9th Cir. 1988) (“PEL”), PEL furnished workers to client businesses and treated the workers as its employees. PEL covered the workers in pension, profit-sharing, and fringe benefit plans. PEL also issued paychecks to the workers, paid the related federal and state employment taxes, and provided workmen’s compensation coverage. PEL received a fee for each worker provided to the client. By contract PEL had the right to terminate or reassign a worker. The workers generally had a preexisting employment and ownership relationship with the clients for whom they worked. PEL reviewed the workers’ qualifications only for the proper professional licenses. The client businesses provided equipment, tools and office space for the workers. In appropriate cases, the client was required to provide malpractice insurance naming PEL as an insured.

Among the factors considered by the courts in PEL were the degree of control over the details of the work; investment in the work facilities; withholding of taxes, workmen’s compensation and unemployment insurance funds; right to discharge; permanency of the relationship; and the relationship the parties think they are creating. Citing Bartels v. Birmingham, 332 U.S. 126 (1947), the Tax Court noted that a contract purporting to create an employer-employee relationship will not control where the common law factors (as applied to the facts and circumstances) establish that the relationship does not exist.

The court found that an employment relationship did not exist between PEL and the workers because PEL exercised minimal, if any, control over the workers; rather, each client and the worker controlled the details of the work and the selection of assignments. PEL did not have a genuine right to terminate or reassign the workers. In addition, PEL had no investment in the work facilities; the clients provided office space, tools and equipment. Despite the contract terms giving PEL control over the workers and labeling the relationship between PEL and the workers as employment, the court found that PEL merely performed a payroll and bookkeeping function. The court held that the workers were not employees of PEL, but of the clients.

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Who Is the Employer?, Continued

Cases Involving Three-Party Relationships (continued)

In Burnetta v. Commissioner, 68 T.C. 387 (1977), a company was formed to do the selection, hiring, training and instruction of workers who would then be contracted out to client businesses, such as Burnetta's. However, in actual practice, the clients did the screening and selection of workers. The client also had the right to discharge a worker and determined the workers' pay. The worker completed time sheets, which the client approved and submitted to the company. The company prepared the workers' paychecks, deducting applicable employment taxes, and mailed them to the clients to give to the workers. The company billed the client monthly and sometimes paid the workers before being paid by the client. The company received a fee based on a percentage of the workers' gross compensation.

The court held that the workers were employees of the clients, not of the company. The court found that the company essentially provided payroll and recordkeeping services for the clients. "In short, Staff simply relieved its business clients (including the petitioner corporations) of the burden of providing their payroll and recordkeeping functions and did not have the right to control its clients' employees in the manner normally associated with and contemplated by the typical common law employer-employee relationship." 68 T.C. at 391 and 399. It was the client, not the company, that interviewed and hired the workers, determined their salaries, and fired them if dissatisfied with their work. The court noted also that the right to control the workers as to the result to be accomplished by their work and the details and means by which the result was accomplished rested with the clients. The company never provided job-related instructions to the workers or had substantial contact with the workers during their employment.

In re Critical Care Support Services, Inc, 138 B.R. 378 (E.D.N.Y. 1992) involved an agency that provided critical care nurses to hospitals. The agency screened the nurses for their qualifications, including licenses, skills and insurance. The agency determined whether to send a nurse to any hospital and also determined the hospitals, duties and shifts to which the nurse was assigned. The agency paid the nurses and billed the hospitals for the nursing services. If a hospital was dissatisfied with a nurse's performance, it notified the agency not to send the nurse again. The agency then decided whether to send the nurse on future assignments to other hospitals.

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Who Is the Employer?, Continued

Cases Involving Three-Party Relationships (continued)

The agency argued that it was not the employer of the nurses because the agency did not actually control the nurses in their performance of services at hospitals; rather the nurses were controlled by the hospital. The court observed that it is difficult to demonstrate the existence of a right to control without evidence of actual exercise of the right. The court noted, however, that the professional critical care nurses, who were carefully screened by the agency, did not have to be actually controlled in their every movement by the agency. The agency retained the right to control the nurses as reflected in its right to assign them to any hospitals (or none at all) or duties, specifying the time and place of the work. The agency also paid the nurses directly, regardless of whether receiving payment from the hospitals. The court held that the nurses were employees of the agency.

In Hospital Resource Personnel Inc. v. United States, 68 F.3d 421 (11th Cir. 1995), another case involving a nurse staffing agency, in addition to considering whether the taxpayer was entitled to relief under section 530 of the Revenue Act of 1978, the court considered whether the staffing agency was the common law employer of the nurses. In concluding that the agency was not the common law employer, the court found persuasive the facts that the agency did not instruct or train the nurses; it did not mandate full-time employment; it was the nurses themselves who provided transportation, incidental expenses, uniforms, tools, and materials; and, in contrast to Critical Care Support Services, *supra*, it neither scheduled the tasks nor set the number of hours the nurses must have worked. In addition, the nurses did not work on the agency's premises, and they were free to provide their services directly to hospitals and to register with other similar nursing agencies.

Revenue Ruling 57-21

In Revenue Ruling 57-21, 1957-1 C.B. 317, the IRS considered whether a licensed physician in residency at a hospital was an employee of an organization for which the physician worked on a part-time basis as part of the physician's clinical training. Under the facts of the ruling, the physician's services were made available to the organization for four hours per week under special arrangements with the hospital. As staff physician for the organization, the physician prescribed medication and recommended treatment for the organization's handicapped workers. The physician directed the nurse in her duties and suggested phases of development for the medical program. The resident did not carry on a private practice. The IRS concluded that the physician was an employee of the organization.³

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Who Is the Employer?, Continued

Dual Functions Determining which institution is the common law employer is complicated by the dual functions that GME programs have. While the primary purpose of GME programs is to train medical doctors in a medical specialty, they also provide residents who perform patient care services. Although it is clear that the sponsoring institution is responsible for resident training, the question arises as to which entity has the right to direct and control the resident's performance of patient care services. The fact that the sponsoring institution evaluates the resident's training progress does not automatically mean that it has the right to direct and control the resident's patient care services. In State of Minnesota v. Apfel, 151 F.3d 742 (8th Cir. 1998), discussed below, the status of the medical school as the employer appears not to have been questioned, so it was not considered or addressed by the court.⁴ The case therefore is not legal authority for the proposition that the medical school is the common law employer of medical residents who perform services at a hospital.

The Common Law Agency Principles Also Apply in the Medical Malpractice Context In analyzing which entity has the right to direct and control residents in performing patient care services, it is instructive to consider which entity would be liable for the negligent act of a resident based upon the application of common law agency principles because these same principles determine whether a common law employment relationship exists.⁵ If liability is not determined by the affiliation agreement, liability would be based upon application of agency principles, including the doctrine of respondeat superior.

Liability Based Upon Respondeat Superior Under the doctrine of respondeat superior, the common law employer is liable in tort for the negligent act of its employee so long as the employee is acting within the scope of employment.⁶ Based upon master-servant agency principles, one writer has suggested that the hospital where services are performed would generally be considered the "general employer" of the resident and thus be liable for the resident's negligence based upon respondeat superior.⁷

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Who Is the Employer?, Continued

Liability Based Upon Respondeat Superior (continued)

However, the writer also suggests that alternative liability may rest with the attending physician or medical school based upon other agency theories. For example, the attending physician may be liable as a “borrowing employer” based upon the borrowed servant doctrine. Under this theory, the hospital remains the general employer, but if the attending physician exercises sufficient control with respect to a particular act, the attending physician may be considered the borrowing employer.”⁸ In addition, the writer suggests that the attending physician or medical school faculty member may be liable along with the hospital under the joint employment theory. Under this theory, alternative liability may be based upon the fact that the attending physician or faculty member has a strong right to control the conduct of a resident who cares for the physician’s patient.⁹

Who Benefits Economically from Resident Patient-Care Services?

It is also instructive to consider for whose benefit (other than the patient) the resident’s services are being performed. In this regard, it is instructive to consider which entity benefits economically from resident services; in other words, who receives payment for resident services? It is our understanding that a hospital does not bill directly for resident services. Instead, as in the case of nursing services, charges for resident services are subsumed within the overall amount billed to a patient receiving care at the hospital. In addition, Medicare subsidizes teaching hospitals for their GME costs, but Medicare does not subsidize medical schools for their GME costs.¹⁰ Thus, the hospital benefits economically from resident patient care services — the activity for which the resident is being compensated.¹¹

Notes

1. The institutions filing refund claims do not assert that the medical residents were independent contractors.
 2. Section 3401(d)(1) defines the term “employer” for purposes of income tax withholding. This section has been made applicable for FICA purposes under Otte v. United States, 419 U.S. 43 (1974), and later cases.
 3. See also Rev. Rul. 55-500 1955-2 C.B. 398 (IRS held that students assigned to a manufacturing corporation by their college pursuant to an agreement between the college and the manufacturing corporation were employees of the corporation for employment tax purposes).
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Who Is the Employer?, Continued

Notes (continued)

4. State of Minnesota involved liability under Minnesota's § 218 agreement, which covered employees of the University of Minnesota. Nothing in the opinion suggests that either side ever questioned whether the University was the employer. In fact, the Government's case was based on coverage of University employees under Minnesota's § 218 agreement. The court opinion does not mention whether the residents were performing services at University facilities or elsewhere. The opinion assumes that the residents were common law employees of the University, but concluded they were not "employees" within the meaning of the § 218 agreement.
5. Of course, residents may held liable for their own malpractice, but plaintiffs will usually seek to hold another party vicariously liable.
6. Restatement (Second) of Agency § 243 (1958).
7. Stewart R. Reuter, M.D., J.D., Professional Liability in Postgraduate Medical Education, Who Is Liable for Resident Negligence?, 15 J.L. Medicine 485, 503-04 (1994) ("The second question [(after examining the affiliation agreement)] is whether the resident is an employee of the hospital. Most courts would answer yes.") citing, for example, Newton County Hospital v. Nickolson, 207 S.E.2d 659 (Ga. App. 1974) ("[W]hen a person is taken directly to a hospital as where he is rendered unconscious in an accident, and a physician hired by the hospital, such as an intern or resident, is guilty of malpractice ... a different situation arises. Such physician usually stands in a position with the hospital, which, under the normal tests of the existence of a master-servant relationship, would call for a ruling that he was the hospital's servant.").
8. Id. at 504-07; Restatement (Second) of Agency § 227 (1958) provides that "[a] servant directed or permitted by his master to perform services for another may become the servant of such other in performing the services. He may become the other's servant as to some acts and not as to others." Comment b. provides that "[i]n the absence of evidence to the contrary, there is an inference that the actor remains in his general employment so long as, by the service rendered another, he is performing the business entrusted to him by the general employer. There is no inference that because the general employer has permitted a division of control, he has surrendered it."

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Who Is the Employer?, Continued

**Notes
(continued)**

9. Id. at 507-09; Restatement (Second) of Agency § 226 (1958) provides that “a person may be the servant of two masters, not joint employers, at one time and as to one act, if the service to one does not involve abandonment of the service to the other.” Under comment b., joint employment occurs when two employers agree to share the services of an employee for a single act.
10. Medicare payments comprise two elements. First, Medicare makes “direct payments, which are determined based upon the number of residents employed by the hospital. 42 CFR § 413.86. Second, Medicare makes “indirect” payments in the form of increases to the teaching hospital’s basic diagnostic related group (DRG) operating payments. 42 CFR § 412.105.
11. The August 1999 report to Congress by the Medicare Payment Advisory Commission entitled, Rethinking Medicare’s Payment Policies for Graduate Medical Education and Teaching Hospitals, page 8, describes resident stipends as follows:

Residents earn a stipend because they provide patient care and perform other services that are of value to the hospital. Other things being equal, this stipend reflects the value of services residents furnish minus the cost of their training. The direct cost of their training is reflected in the remaining direct GME expenses for faculty supervision, administrative staff, and faculty overhead. In principle then, the direct GME costs that hospitals report on their Medicare cost reports represent the net value of the patient care services residents provide.

Developing the Facts on Who is the Employer — Behavioral Control, Financial Control, and the Relationship of the Parties

In determining whether an individual is an employee under the common law rules, case law and rulings have looked to a variety of facts as indicating whether sufficient control is present to establish an employer-employee relationship. As noted above, the same facts will determine which of two entities is the employer. The degree of importance of the facts varies depending upon the occupation and the factual context in which the services are performed. See Revenue Ruling 87-41, 1987-1 C.B. 296, 298-99. To analyze the relevant facts, items of evidence can be grouped into the following three main categories: behavioral control, financial control, and the relationship of the parties.

General Information on the Residency Program

As a starting point, the agent should determine (1) the identity of the sponsoring institution, (2) the type and duration of the residency programs at issue in the claim, (3) the number of residents in each program, and (4) whether rotations are performed at participating institutions and the duration of any such rotations. This information may be obtained from the claim, the taxpayer, or from other sources such as the Green Book or through Internet research.¹

Documentary evidence involving medical residents and sponsoring institution faculty (attending physicians), such as employment contracts and position descriptions, is highly relevant for purposes of determining the facts with respect to behavioral control, financial control, and the relationship of the parties. In addition, the affiliation agreements between the sponsoring institution and any affiliated teaching hospitals are relevant for purposes of determining the parties' intent with respect to the relationship as well as in determining the entity that has the right to direct and control the resident.²

Continued on next page

Developing the Facts on Who is the Employer — Behavioral Control, Financial Control, and the Relationship of the Parties, Continued

Documentary Evidence

The following documents are relevant in developing the facts in these cases:

- Any written policies/procedures relating to limits on the patient care service aspects of the program.
- Any contracts/affiliation agreements between the sponsoring institution and the participating institution(s) with respect to the GME program.
- Any agreements a resident must sign upon entering the residency program.³ (Determine if there are additional agreements signed as the training program progresses).
- A resident handbook or bulletin, if any, provided to residents.
- Position description(s) for Medical Residents, if any. Does the position description change as the training program progresses?
- Any contracts between the sponsoring institution and its attending physicians/faculty members that address the attending physicians' responsibilities with respect to the supervision of resident patient care services. Check on whether separate contracts exist between the participating hospitals and the attending physicians with respect to the supervision of resident services.
- The sponsoring institution's position description(s), if any, for an attending physician/faculty member. What does the position description say with respect to the supervision of resident services or the training/education of residents?

In addition, if the residency program is accredited, the specific program requirements as set forth by the accrediting body should be reviewed to identify any other pertinent documents.⁴

Behavioral Control

Evidence in this category includes facts regarding whether a business has the right to direct and control how the worker performs the specific tasks for which the worker is hired. Facts that show behavioral control include the type and degree of instructions given to the worker and the training the business gives the worker. It is important to remember that there will typically be some facts indicating behavioral control by both the sponsoring and participating institution.

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Developing the Facts on Who is the Employer — Behavioral Control, Financial Control, and the Relationship of the Parties, Continued

Behavioral Control (continued)

There are certain facts which will generally be consistent from case to case which indicate that a hospital where services are performed has behavioral control over residents. The hospital will generally determine the hours a resident is to work.⁵ In addition, the hospital receives payment for resident patient care services, including Medicare reimbursement; thus creating an incentive to monitor their services.

There are other facts which are properly viewed as neutral facts because they are common to all hospital-physician relationships. These include the facts that the services will be performed on the hospital's premises, the hospital sets policies and procedures with respect to patient care, and the resident will generally use the hospital's equipment, facilities and support staff. Instead, facts indicating that the hospital generally has more detailed policies and procedures with respect to patient care services performed by residents than for other physicians are more relevant for purposes of determining behavioral control.

Certain facts will typically indicate that the sponsoring institution has behavioral control over residents. Sponsoring institution faculty provide instructions and training to residents with respect to the provision of patient care services. These instructions may be very detailed, especially in the early years of a residency. Also, an accredited sponsoring institution will have an evaluation system in place which serves as means to direct and control the performance of services by a medical resident.

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Developing the Facts on Who is the Employer — Behavioral Control, Financial Control, and the Relationship of the Parties, Continued

Facts To Be Developed with Respect to Behavioral Control

Other facts to be developed with respect to behavioral control include:

- To what extent does the hospital or sponsoring institution require the resident to make time/activity reports?
- Do the contracts/affiliation agreements between the sponsoring institution and the participating hospitals address supervision of resident patient care services? Do these contracts designate an entity as the employer having the right to direct and control the medical residents? Do these contracts designate an entity that would be liable in the event of resident negligence?
- Does the hospital have in place separate safeguards/controls or policies, possibly set forth in a “house staff manual,” governing patient care services performed by residents? Are any of these special procedures mandated by federal or state law (such as Medicare)?
- Do contracts with faculty/attending physicians address supervision of patient care services performed by residents?
- What procedures are in place with respect to attending physicians’ reporting to the sponsoring institution regarding a resident’s performance? Are there forms used for this purpose?
- To what extent are residents subject to less supervision as their training program progresses?
- To what extent do more senior medical residents (second year residents and beyond) supervise less senior residents?
- Does the hospital or the sponsoring institution assign the attending physicians who are to supervise the resident’s services?

Financial Control

Evidence under this category include facts regarding whether there is a right to direct and control how the economic aspects of the worker’s activities are conducted. The fact that the sponsoring institution generally pays the residents notwithstanding whether it receives payment from the participating hospital suggests financial control by the sponsoring institution.

Continued on next page

Developing the Facts on Who is the Employer — Behavioral Control, Financial Control, and the Relationship of the Parties, Continued

Facts To Be Developed with Respect to Financial Control

With respect to financial control, other facts to be developed include:

- Does the hospital or the sponsoring institution provide medical malpractice insurance to residents?
 - Does the hospital or sponsoring institution have a policy with respect to outside employment? Does any such policy change as the resident proceeds through the residency program?
 - If the resident incurs expenses that are reimbursable, which entity reimburses them? Do the participating hospitals provide benefits to residents in addition to the stipend and benefits (if any) paid to the resident by the sponsoring institution?
-

Relationship of the Parties

Evidence under this category includes facts which illustrate how the parties perceive their relationship. Relevant facts include those which show the intent of the parties with respect to control.

Certain facts suggest that the parties perceive the sponsoring institution to be the employer. Residents might have a more permanent relationship with the sponsoring institution than with a hospital where services are performed. In addition, the sponsoring institution can terminate the resident for failure to make satisfactory progress in the training program.

On the other hand, the services performed by residents for a hospital are a key aspect of the regular business of the hospital. As a result, there is an increased probability that the hospital will direct and control their activities.

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Developing the Facts on Who is the Employer — Behavioral Control, Financial Control, and the Relationship of the Parties, Continued

Facts To Be Developed with Respect to the Relationship of the Parties

- Did the hospital where services were performed play any role in determining which candidates were accepted into the residency program or which residents would be assigned to the hospital?
- Did either entity provide the resident with benefits normally associated with an employment relationship such as retirement, worker's compensation, health care, and vacation benefits?
- In the case of poor performance by the resident, does the hospital have the authority to terminate the resident or preclude the resident from performing further services at the hospital?
- Did the hospital independently verify that a resident had the required license/credentials?
- Do contracts between the sponsoring institution and residents place an employer-employee label on the relationship?
- Do contracts between the sponsoring institution and participating hospitals state that either party is the residents' employer?
- Does state law place any particular status on residents? For example, does state law classify them as employees for worker's compensation insurance purposes? Has the hospital ever used state worker's compensation laws to limit liability with respect to a claim made by a resident?
- Have the residents attempted to negotiate collectively with the sponsoring institution or participating hospitals?

Based upon the facts and circumstances, if it is determined that the common law employer is a state or local government entity, such as a state university, it must be determined whether the resident's services are covered under a § 218 agreement.⁶

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Developing the Facts on Who is the Employer — Behavioral Control, Financial Control, and the Relationship of the Parties, Continued

Notes

1. General information regarding the residency program at issue can likely be obtained through Internet research, including FREIDA online (Fellowship and Residency Electronic Interactive Database Access) at www.ama-assn.org/frieda.
 2. Of course the substance of the relationship, not the label placed on it, governs the resident's status. § 31.3121 (d)-1 (a)(3) of the regulations; Bartels, supra (the Supreme Court determined that orchestra leader was the employer of the orchestra members despite contracts which designated the dance halls where the orchestra performed as the common law employer). However, the designation or description of the relationship is important in close cases. See Illinois Tri Seal Prods., Inc., v. United States, 353 F.2d 216, 218 (Ct. Cl. 1965).
 3. The ACGME requires a written agreement setting forth the conditions of the appointment.
 4. See, for example, the ACGME program requirements for internal medicine and radiology which are included in these materials as Exhibit 4.
 5. In New York, the hospital is responsible for seeing that the so-called "Libby Zion regulations" are followed. These regulations, which are set forth at § 405.4 of the New York Health Code (10 NYCRR 405.4), require that the hospital establish certain limits and monitor the working hours of medical residents. These regulations also require that hospitals adopt and enforce specific policies regarding moonlighting to ensure that medical residents are not fatigued when performing patient care services. Similar laws do not exist in other states, but limits may be imposed by the programs.
 6. If the state or local government entity is determined not to be the common law employer, so that the residents are not its employees, the residents would not be covered under the entity's § 218 agreement. Instead, whether the resident's services are subject to FICA must be determined on the basis of the relationship with the common law employer. However, if the state or local government entity pays the residents, it could be liable for any FICA tax that applies, as the statutory employer under § 3401(d)(1).
-

FICA Coverage of State and Local Government Employees

FICA taxes can apply to services performed by residents who are state and local government employees in either of two ways. First, an employee's service can be covered by a § 218 agreement between the state and the SSA. Such agreements provide state and local government employees with social security coverage.¹ Second, if an employee's service is not covered under a § 218 agreement, then whether FICA tax applies depends on whether the employee's service is subject to FICA tax under §§ 3101-3126 of the Code. Before 1991, social security coverage of state and local government employees was available only under a § 218 agreement; those employees were excluded from coverage under the FICA. However, since 1991, § 3121(b)(7)(F) provides that state and local government employees are covered under the FICA unless they participate in a retirement system that provides them with minimum retirement benefits that are comparable to the retirement benefits provided under social security.

Are the Employer's Employees Covered Under a § 218 Agreement?

If the employer is a state or local government entity, the IRS must determine whether the resident's service is covered by the state's § 218 agreement. When a state enters into a § 218 agreement with the SSA, employees of the state and its political subdivisions are brought under the agreement in groups known as "coverage groups." The Act gives each state the right to decide which coverage groups to include under its § 218 agreement. Coverage groups fall into two categories: employees who are not covered under a state retirement system and employees who are covered under a retirement system. For example, one possible coverage group is the employees of each institution of higher education who are covered under the state retirement system.

The State Social Security Administrator (SSSA)

Each state designates an official to act for the state in matters involving the SSA and its § 218 agreement. This person is known as the "State Social Security Administrator (SSSA). Further information on the procedures for obtaining information from the SSSA will be provided soon. The State Social Security Administrator or the SSA can help answer questions on whether a particular employer's employees are included within a coverage group. See Exhibit 3 for a list of SSSAs.

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FICA Coverage of State and Local Government Employees, Continued

The Optional Student Exclusion

The state's § 218 agreement determines which employees within each coverage group are covered by its terms. In addition to certain mandatory exclusions from coverage under a § 218 agreement, § 218(c) of the Act provides that certain services may be excluded from coverage upon election by the state. For example, under § 218(c)(5), a state has the option of excluding the services of students. Section 218(c)(5) provides that the optional exclusion will apply only to students who would be excluded under the general student exclusion provided under § 210(a)(10) of the Act. Section 210(a)(10) provides for a general exclusion from social security coverage for services performed for a S/C/U (or an organization that is a related § 509(a)(3) organization with respect to the S/C/U) by a student who is enrolled and regularly attending classes at the S/C/U.²

But if a state has chosen not to exclude student services under its agreement, those services will be covered under social security notwithstanding the general student exclusion under § 210(a)(10) of the Act.³ Thus, if the state covers student services under its § 218 agreement, medical resident services will be covered under the FICA even if the requirements for the student FICA exception under § 3121 (b)(10) are otherwise met.

The SSA's Role in Determining § 218 Agreement Coverage

Even if the state's § 218 agreement excludes students from coverage as permitted by § 218(c)(5) of the Act, the exclusion might not apply to medical residents. This will depend upon whether the resident is a student within the meaning of § 210(a)(10) of the Act. The SSA has jurisdiction over the proper interpretation of § 218 agreements and the pertinent provisions of the Act for purposes of determining whether an individual is entitled to social security benefits, including whether a medical resident is a student within the meaning of § 210(a)(10) of the Act. The SSA litigated the issue of whether residents were covered under a § 218 agreement in State of Minnesota v. Apfel, 151 F.3d 742 (8th Cir. 1998).⁴

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FICA Coverage of State and Local Government Employees, Continued

State of Minnesota

State of Minnesota involved medical residents who were enrolled in the GME program at the University of Minnesota (“University”). One issue considered by the court was whether the residents were students within the meaning of § 210(a)(10) of the Act and thus excluded from coverage under Minnesota’s § 218 agreement. The SSA asserted that the purpose of the stipends paid to the residents was primarily compensatory and therefore the purpose of the relationship must have been primarily to earn a livelihood. In addition, the SSA cited Social Security Ruling 78-3, which sets forth SSA position that resident physicians are not “students” for purposes of the student services exclusion under § 210(a)(10) of the Act.

In rejecting the SSA’s arguments, the court cited 20 C.F.R. § 404.1028(c), which provides that “[w]hether you are a student for purposes of this section depends on your relationship with your employer. If your main purpose is pursuing a course of study rather than earning a livelihood, we consider you to be a student and your work is not considered employment.” Thus, the court held that it was not determinative that the stipends are paid for services performed; rather, the critical inquiry is the nature of the relationship between the University and the medical residents.⁵ The court also rejected SSR 78-3 because its “bright-line rule” is inconsistent with the approach set forth at 20 C.F.R. § 404.1028(c), which contemplates a case-by-case examination of the individual’s relationship with the S/C/U.⁶

In examining the facts, the court found persuasive that the residents were enrolled at the University, paid tuition, and were registered for approximately fifteen credit hours per semester. Based upon these facts, the court concluded that the primary purpose of the residents’ participation in the program was to pursue a course of study rather than to earn a livelihood.⁷

Acquiescence Ruling 98-5 (8), 63 F.R. 58444

In response to the State of Minnesota decision, the SSA issued Acquiescence Ruling 98-5 (8), 63 F.R. 58444. Ruling 98-5 applies only to employers located in the 8th Circuit (Minnesota, the Dakotas, Nebraska, Iowa, Missouri and Arkansas). The ruling provides that, in applying the student services exclusion within the 8th Circuit, SSA will make a case by case examination of the relationship of medical residents with the employer S/C/U to determine whether the residents meet the statutory criteria of being enrolled and regularly attending classes. In evaluating the relationship, the SSA will consider all the facts and circumstances.

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FICA Coverage of State and Local Government Employees, Continued

Notes

1. Section 3121(b)(7)(E) of the Code provides that service covered under a § 218 agreement constitutes employment for purposes of the FICA.
2. Section 210(a)(10) of the Act is the parallel provision to § 3121(b)(10) of the Code. Section 210(a)(10) provides that the term “employment” does not include

[s]ervice performed in the employ of (A) a school, college, or university, or (B) an organization described in section 509(a)(3) of the Internal Revenue Code of 1986 if the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of a school, college, or university and is operated, supervised, or controlled by or in connection with such school, college, or university, unless it is a school, college, or university of a State or a political subdivision thereof and the services in its employ performed by a student referred to in section 218(c)(5) are covered under the agreement between the Commissioner of Social Security and such State entered into pursuant to section 218; if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university.

3. Section 2023 of Public Law 105-277 (the Balanced Budget Act), enacted October 21, 1998, provided an exception to the general rule that states may not amend their § 218 agreements to exclude certain groups from coverage. The legislation provided a limited window of time for states to modify their existing § 218 agreements to exclude services performed by students employed by the public school, college, or university where they are regularly attending classes. The legislation provides that to obtain this exclusion, the § 218 agreement must have been modified after December 31, 1998, and before April 1, 1999. Any modification made under this section will be effective with respect to services performed after June 30, 2000.

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FICA Coverage of State and Local Government Employees, Continued

**Notes
(continued)**

4. State of Minnesota involved the tax years 1985 and 1986. Under the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, the IRS became responsible for determining liability for social security taxes under a § 218 agreement with respect to remuneration for services paid after December 31, 1986.
 5. 151 F.3d at 747.
 6. Id. at 748.
 7. Id.
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Employer Status Requirement

Under § 3121(b)(10), the Student FICA exception is available only with respect to services performed in the employ of a S/C/U or a related § 509(a)(3) organization.¹ Section 31.3121(b)(10)-2(d) of the regulations provides that the term “school, college, or university” for purposes of the student FICA exception is to be construed in its “commonly or generally accepted sense.” A medical school will clearly qualify as a S/C/U. However, if the hospital where services are performed is the common law employer, but is not part of the medical school, the question arises whether the hospital qualifies as a S/C/U or a related § 509(a)(3) organization to a S/C/U.

Revenue Procedure 98-16

Revenue Procedure 98-16, 1998-5 I.R.B. 19, sets forth generally applicable standards for determining whether services performed by students in the employ of certain institutions of higher education qualify for the exception from FICA tax provided under § 3121(b)(10). For purposes of Rev. Proc. 98-16, the term “institution of higher education” includes any public or private nonprofit school college, university, or affiliated organization described in § 509(a)(3) of the Code that meets the requirements set forth in Department of Education (DOE) regulations at 34 C.F.R. § 600.4. These regulations define an institution of higher education, in relevant part, as an institution that (1) is in a state, (2) admits only high school graduates, (3) is authorized by the state to provide a post-secondary educational program, and (4) is accredited or preaccredited by a “nationally recognized accrediting agency” as defined in the DOE regulations at 34 C.F.R. § 600.2.

Revenue Procedure 98-16 Does Not Apply to Medical Residents

The revenue procedure provides at § 2.02 that the standards contained in it do not apply to the treatment of postdoctoral students, postdoctoral fellows, medical residents, or medical interns because services performed by these employees cannot be presumed to be for the purpose of pursuing a course of study. Thus, whether a hospital is a S/C/U must be considered in light of the “commonly or generally accepted sense” test set forth in the regulations. While the tests under the DOE regulations are relevant in determining whether a hospital may be considered a S/C/U for purposes of § 3121(b)(10), whether any hospital meets or fails to meet the DOE standards is not a controlling standard as it is in the case of an institution that seeks to use the safe harbor of the revenue procedure.²

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Employer Status Requirement, Continued

**Are Hospitals
S/C/Us?**

We believe that a hospital that is not part of the same legal entity as a medical school or university generally does not fit within the common or generally accepted meaning of the term “school, college, or university.”³

**Is a University
Hospital a
Separate
Employer from
the University?**

If the resident is employed by a hospital that is part of a university, the question arises whether the hospital is a separate employer from the university. This is important because, as stated, a university medical school is clearly a S/C/U, whereas a hospital generally is not. If they are incorporated separately under state law, they are separate legal entities for federal tax purposes and are separate common law employers for employment tax purposes, including the student FICA exception. A simple starting point in making this determination is whether the hospital and the university have different EINs. Different EINs indicate that they generally are separate taxpayers and separate employers. Assertions that they are not separate should be carefully examined.

If the hospital and medical school report wages under the same EIN, they may or may not be a single employer. Even if wages paid to university employees and medical residents are reported under the same EIN, the university may be merely acting as a common paymaster under § 3121(s) or a payroll agent under § 3504 with respect to wages paid by the two separate legal entities. Thus, if wages are reported under the same EIN, it must be determined whether the university hospital is incorporated separately under state law.

If the residents are employees of the hospital and the hospital and university medical school are separate employers, the employer status requirement is not met unless the hospital is a § 509(a)(3) organization in relation to the S/C/U.⁴

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Employer Status Requirement, Continued

**Section
509(a)(3)
Organizations**

Under § 3121(b)(10)(B) of the Code, the student FICA exception may be available if a hospital is a related § 509(a)(3) organization with respect to an affiliated S/C/U. Some other type of affiliation between the hospital and a S/C/U is not enough. Section 3121(b)(10)(B) and § 31.3121(b)(10)-2(a)(2) of the regulations are very specific about the relationship required when the employer is not a S/C/U. It appears that the word “affiliated” in § 31.3121(b)(10)-2(b) and (c) of the regulations has caused some tax advisors to believe that a contractual relationship created by an affiliation agreement with a participating institution is sufficient to satisfy the employer status requirement. It is not “affiliated” when used in § 31.3121(b)(10)-2(b) and (c) means having a § 509(a)(3) relationship. Any other interpretation would be inconsistent not only with § 31.3121 (b)(10)-2(a)(2), but also with § 3121(b)(10)(B), that is, the statute itself.⁵

Section 3121(b)(10)(B) provides that the student FICA exception applies with respect to services performed in the employ of an organization described in § 509(a)(3) if (1) the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions, or to carry out the purpose of a S/C/U, and (2) is operated, supervised and controlled by or in connection with the S/C/U. This section’s language incorporates the tests set forth under § 509(a)(3)(A) and (B) of the Code. In addition, § 509(a)(3)(C) requires that the § 509(a)(3) organization may not be controlled, directly or indirectly, by disqualified persons (as defined in § 4946).

**Section
509(a)(3)
Requirements**

Thus, a § 509(a)(3) organization must meet four requirements:

- (1) An organizational test (§ 509(a)(3)(A)).
 - (2) An operational test under § 509(a)(3).
 - (3) A relationship test (§ 509(a)(3)(B)).
 - (4) An absence of disqualified persons (§ 509(a)(3)(C)).
-

**Organizational
Test**

If the taxpayer is claiming that the employer-status requirement is met by virtue of the fact that it is § 509(a)(3) organization in relation to a S/C/U, the taxpayer’s organizing instruments (articles of incorporation and bylaws) must be analyzed to determine whether the organizational test has been met.⁶ For a hospital that is part of a university, the “organizational” and “absence of disqualified persons” tests will generally be met.

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Employer Status Requirement, Continued

Operational Test

In addition to being organized as a § 509(a)(3) organization, the entity must also at all times be operated exclusively for the benefit of, to perform the functions of or to carry out the purposes of the S/C/U. The organization's actual activities must be analyzed to determine whether the operational test is met.⁷

Relationship Test

The relationship test offers three alternatives for qualification:

The hospital would have to be:

- (1) Operated, supervised or controlled by the university.
- (2) Supervised or controlled in connection with the university.
- (3) Operated in connection with the university.

The relationship under the first test is comparable to a parent/subsidiary relationship and is established by the fact that a majority of the officers, directors or trustees of the hospital are elected or appointed by the university. The relationship under the second test contemplates a brother/sister relationship. This is established by finding common supervision or control by persons supervising or controlling both organizations.

The third test contemplates two independent organizations but with a strong commonality of purpose and operation. This test is met if the hospital is both "responsive to" the university and operates as an "integral part" of the university.⁸

Section 509(a)(3) Should Be Considered When the Employer Is Other Than a Medical School

If the common law employer is other than a medical school, it should be considered whether the common law employer is a related § 509(a)(3) organization. For example, if a university hospital associated with a university medical school is the common law employer (and if the university hospital is not part of the same legal entity as a university or university hospital), the IRS should consider whether the hospital is a related § 509(a)(3) organization by virtue of the hospital's relationship with the university or the university medical school. We note that, as stated, the existence of an affiliation agreement, without more, will not render a participating institution a related § 509(a)(3) organization.

Similarly, if a medical school faculty practice plan is the common law employer, the IRS should determine whether the faculty practice plan is a related § 509(a)(3) organization with respect to the university or the university medical school.

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Employer Status Requirement, Continued

Considerations if the Related S/C/U Participates in a State's § 218 Agreement

Although an entity is a related § 509(a)(3) organization, the student FICA exception might not be available if the S/C/U is a state or local government employer. Under § 3121(b)(10)(B), if the related S/C/U is an entity that participates in a state's § 218 agreement, and that state has chosen to cover students under its agreement, then the student FICA exception is not available to the related § 509(a)(3) organization. The legislative history to this provision states that “[§ 3121(b)(10)(B)] would not exclude from coverage services of a student for an auxiliary nonprofit organization connected with a public school, college, or university whose student employees are covered under social security pursuant to a State coverage agreement with the Secretary.” H.R. Rep. No. 231, 92d Cong., 1st Sess. 63 (1971); S. Rep. No. 1220 92d Cong., 2d Sess. 150 (1972). Thus, although the employees of the § 509(a)(3) organization are not themselves covered under a § 218 agreement, § 3121(b)(10)(B) requires that the IRS look to the § 218 agreement for purposes of determining whether the student FICA exception is even available.

Summary of Employer Status Requirement

To summarize, the student FICA exception applies only if the employer is a S/CIU or a related § 509(a)(3) organization. A medical school is a S/C/U within the meaning of § 3121(b)(10). A hospital would generally not be considered a S/C/U for purposes of the student FICA exception because it is not a S/C/U within the common or generally accepted sense. However, an entity such as a university hospital may be considered a S/C/U either because it is part of the same legal entity as the university or because it is a related § 509(a)(3) organization. A faculty practice plan may also satisfy the S/C/U requirement if it is a related § 509(a)(3) organization. If the S/C/U is a state or local government entity, the student FICA exception is not available with respect to services performed for the related § 509(a)(3) organization if the state has chosen to cover student services under its § 218 agreement.

Continued on next page

Employer Status Requirement, Continued

Notes

1. Note that the employer status requirement applies also under § 210(a)(10) of the Act.
 2. We note that neither the ACGME nor the AOA is a “nationally recognized accrediting agency” within the meaning of the regulations at 34 CCFR § 600.2. It is our understanding, however, that these organizations have not sought recognition by the DOE as a nationally recognized accrediting agency.
 3. In construing a statute, courts generally seek the plain and literal meaning of its language. United States v. Locke, 471 U.S. 84, 93, 95-96 (1985). More specifically, words in a revenue act generally are interpreted in their “ordinary, everyday senses.” Commissioner v. Soliman, 506 U.S. 168, 174 (1993) (quoting Malat v. Riddell, 382 U.S. 669, 571 (1966) (quoting Crane v. Commissioner, 331 U.S. 1, 6 (1947))); see also Helvering v. Horst, 311 U.S. 112, 118 (1940) (“[c]ommon understanding and experience are the touchstones for the interpretation of revenue laws.”).
 4. Note that State of Minnesota does not stand for the proposition that a university hospital and a university medical school are a single employer for purposes of § 3121(b)(10). The case involved the interpretation of the State’s § 218 agreement which referred only to employees of the University of Minnesota generally. As discussed above, the court did not address the issue of whether the University was the common law employer.
 5. Note also that State of Minnesota does not establish a legal basis for accepting any relationship other than a § 509(a)(3) relationship. As discussed above, the court did not consider or decide the question of whether the University was in fact the employer of the medical residents. In addition, State of Minnesota does not stand for the proposition that a university hospital is a S/C/U because, to the extent that the employer’s status as a S/C/U was relevant, it would have been taken for granted since the University was assumed to be the employer.
 6. See Income Tax regulations § 1.509(a)-4(c).
 7. See Income Tax regulations § 1.509(a)-4(e).
 8. The responsiveness and integral part tests are set forth in the regulations at § 1.509(a)-4(i).
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The Student Status Requirement

In addition to the employer status requirement under § 3121(b)(10), a resident with respect to whom the refund claim is filed must be a “student who is enrolled and regularly attending classes at [the S/C/U].” Section 31.3121(b)(10)-2(c) of the regulations provides that whether an employee has the status of a student is determined on the basis of the employee’s relationship with the S/C/U for which the services are being performed. An employee who performs services in the employ of a S/C/U “as an incident to and for the purpose of pursuing a course of study” at the S/C/U has the status of a student in the performance of those services. Section 31.3121 (b)(10)-2(b) provides that if an employee has the status of a student, then “the amount of remuneration for services performed by the employee in the calendar quarter,¹ the type of services performed by the employee, and the place where the services are performed are immaterial” for purposes of the student FICA exception. Thus, the fact that a resident’s pay is much higher than students generally or much lower than a board certified physician is irrelevant. In addition, the fact that residents provide patient care services does not of itself preclude student status.

Although we believe the employer status requirement is not met in the case of a resident who participates in a hospital-sponsored residency program (if the hospital is not a related § 509(a)(3) organization), we recommend that in all cases the facts regarding student status be developed.

Even though Revenue Procedure 98-16 provides that the objective standards contained in the revenue procedure do not apply to, *inter alia*, medical residents because the services performed by medical residents cannot be assumed to be incidental to and for the purpose of pursuing a course of study, this does not mean they cannot be students. Instead, it means that determination of the status of these employees as students requires examination of the facts and circumstances and cannot be determined only by reference to the guidelines set forth in Revenue Procedure 98-16. A *per se* position that medical residents are not students within the meaning of § 3121(b)(10) would be inconsistent with the regulations and Revenue Procedure 98-16.²

Continued on next page

The Student Status Requirement, Continued

Although State of Minnesota involved status as a student under § 210(a)(10) of the Act, it is instructive as to the facts and circumstances a court may consider in determining student status. In State of Minnesota, the court framed the issue by stating that “if the residents’ participation in University’s training program is primarily educational, the residents should be considered students. If their purpose is to earn a living, however, they do not fit within the definition of student exclusion.”³ In determining whether the services were primarily educational or for the purpose of earning a living, the court found persuasive the facts that the residents were enrolled at the University, paid tuition, and were registered for approximately fifteen credit hours per semester.

Developing the Facts Regarding Student Status

As an initial matter, if the residency program is accredited, the educational program requirements of the accrediting body should be determined. For example, in the case of an ACGME-accredited residency program, the ACGME educational program requirements for the type of residency program should be determined.⁴ If a formal educational program existed, the facts should be developed regarding whether the educational program was followed in practice during the years involved in the refund claim.

The following are relevant facts and circumstances to be developed in addition to those found to be relevant in State of Minnesota:

- How are residents taught? For example, are there regularly scheduled lectures and classroom time? Do the residents participate in formal “teaching rounds”? If so, is there a record of the teaching rounds that have taken place?
- Are the medical residents evaluated by faculty members of the S/C/U based upon academic standards? Is there a standard program of tasks/assignments based upon increased knowledge and performance evaluations?
- Can a resident be terminated from the residency program for failure to meet academic standards (which may, of course, include clinical performance)?
- Are the residents required to take exams or prepare research projects?
- What percentage of the residents’ time is spent in direct patient contact versus the time spent in classroom study, formal teaching rounds or other activities which may be considered the equivalent of classroom activities?⁵ (See “Enrolled and Regularly Attending Classes” below).
- During what percentage of patient care time is the resident actually accompanied by the attending physician?

Continued on next page

The Student Status Requirement, Continued

Developing the Facts Regarding Student Status (continued)

- What percentage of patient care time is spent in patient care in which the resident's actions must be approved in advance?
 - If a university is the employer, how is the resident classified by the university? For example, can the resident receive the benefits that other students are entitled to such as student health insurance, discount event tickets, student housing, and library access?
 - Will the training program lead to obtaining a degree or certificate?
 - Is the resident provided with benefits, e.g., sick leave, disability coverage, vacation, eligibility to participate in a retirement plan, which are typically provided to employees, not students?
-

Do the Facts and Circumstances Change as the Residence Progresses?

It must be determined whether the facts and circumstances relative to student status change as the resident proceeds from one year to the next through the program. For example, does the amount of classroom time or other didactic activities change after the first year of residency? If formal teaching rounds are part of the educational program, does the time spent on teaching rounds as opposed to "management rounds" or "work rounds," which are not primarily for the purpose of teaching, change as the training program progresses?⁶ In addition, does a resident at some stage in the residency become actively involved in supervising less experienced residents?

"Enrolled and Regularly Attending Classes"

The student must be "enrolled and regularly attending classes" at the S/C/U. This language may be read to suggest that Congress envisioned a traditional classroom environment. The question therefore arises whether the employee must participate in traditional classroom activity or whether other didactic activities, including research activities and supervised practice, may fulfill this requirement.

Revenue Ruling 78-17, 1978-1 C.B. 306, situation 3, considered whether services performed for a university by a Doctor of Education student, who was conducting research and experimentation needed for the student's dissertation, were excepted under the student FICA exception. The Service concluded that the service was excepted from employment because the dissertation was required to obtain the desired academic degree and the student was actually enrolled at the university. Thus, the ruling carves out an exception to the "regularly attending classes" requirement in circumstances where the employee is enrolled at the university and is completing the requirements for an academic degree.

Continued on next page

The Student Status Requirement, Continued

“Enrolled and Regularly Attending Classes” (continued)

We do not believe “classes” should be interpreted narrowly to include merely traditional lecture/discussion and lab sessions. Instead, regularly scheduled events, whether or not in a classroom, including lectures, demonstrations, tutorials, and teaching rounds, at which a faculty member plays a leadership role in furthering the objectives of an established curriculum, may be considered classes for purposes of the student FICA exception. The frequency of events such as these determines whether the medical resident may be considered to be “regularly attending classes.”

Residents Similar to Other Professionals

It should be noted that residency programs fulfill the requirements for certification in a particular specialty area and thus are similar in some respects to the requirements that other professionals such as architects and accountants must meet to receive licensing/certification. For example, accountants undergo a similar post-secondary process. Accountants must obtain a Bachelor’s degree and complete a period of work experience before being eligible for a Public Accountant’s license.⁷ Similarly, architects must complete a five-year bachelor of arts program or a six-year masters program followed by a working internship which generally lasts three years. After completing the internship, the architect may take a certification exam, which the architect must pass in order to become fully licensed.⁸

Student Status Summary

Whether a medical resident is a student depends upon examination of all the facts and circumstances. A particular claim should be examined on a program by program and a year-by-year basis. Thus, the written educational program of each residency program should be reviewed and it should be determined whether this written educational program changes from year to year as a residency progresses. It is also necessary to determine how the program operated in practice; in other words, whether in practice the written program requirements have been followed. In this regard, contemporaneous records of events such as teaching rounds, seminars and other activities described above as being the equivalent to classroom activities are highly relevant in determining whether the resident was a student.

Continued on next page

The Student Status Requirement, Continued

Notes

1. Before 1950, services performed by a student enrolled and regularly attending classes for a S/C/U not exempt from income tax were not “employment” to the extent the remuneration for these services did not exceed \$45 in a calendar quarter; however, remuneration for student services performed for a S/C/U exempt from income tax were not subject to a dollar limit per quarter. Social Security Act Amendments of 1939, Pub. L. No. 76-379 §§ 201, 606 53 Stat. 1360, 1374-75, 1384-85 (1939). In 1950, the quarterly limit on remuneration paid to an employee/student of a nonexempt S/C/U was eliminated and the separate student exclusion provisions for exempt and nonexempt entities were combined. Social Security Amendments of 1950, Pub. L. No. 81-734, § 104(a), 64 Stat. 477, 497, 531 (1950).
2. Note the description of residents’ day-to-day activities and responsibilities in the recent NLRB decision (Boston Medical Center and Committee of Interns and Residents, 330 NLRB No. 30, 1999 NLRB Lexis 821) and the recent series of articles in the New York Times (N.R. Kleinfield, Life, Death, and Managed Care, November 14-17, 1999). See also, S. Jauhar, Medical Residents, Yes, But Workers, Too, New York Times, April 18, 2000.
- 3 151 F.3d at 748.
4. The educational program requirements may vary based on the type of residency program. For example, the ACGME education program requirements for internal medicine appear to be more detailed than those for Radiology. See Exhibit 4.

Continued on next page

The Student Status Requirement, Continued

**Notes
(continued)**

5. The 1998-1999 statistical information in the following chart was obtained from a document published by the American Medical Association entitled Characteristics of Graduate Medical Education Programs and Resident Physicians By Specialty.

The Average Hours on Duty Per Week During the First Year of Scheduled ACGME-Accredited Residency Program	
Specialty/Subspecialty	Hours on Duty Per Week
Family Practice	64.1
Internal Medicine	66.1
OB/Gyn	74.8
Pediatrics	71.4
Radiology	51.1
General Surgery	79.9
Thoracic Surgery	73.1

6. See Exhibit 4, Program Requirements for Residency Education in Internal Medicine, pages 10-11 (in describing the formal teaching program requirements for internal medicine residency programs, the ACGME distinguishes between teaching rounds, which are intended to be for educational purposes, and “management rounds” and “work rounds,” which appear to be primarily for the purpose of ensuring adequate patient care).
7. Information obtained from the American Institute of Certified Public Accountants (AICPA).
8. Information obtained from the American Institute of Architects (AIA).
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Refund Claim Procedures Must Be Followed

The employer must fulfill certain procedural requirements in order to receive a refund of the employer and employee portions of FICA tax. Generally, the employer has a duty to first “adjust” the employee portion of FICA as a condition to receiving a refund for the employer and employee portions of FICA.¹ The following provisions describe the conditions which must be met in order for an employer to receive a refund of employee and employer portions of FICA, and under what circumstances an employer can receive a refund of only the employer portion of FICA.

Employer’s Duty to First Adjust the Employee Portion of FICA

Section 6413(a) of the Code provides that if more than the correct amount of employer or employee FICA tax is paid on any payment of remuneration, proper adjustments, of both the tax and the amount to be deducted, must be made, without interest, as prescribed by regulations.

Section 6413(b) of the Code provides that if more than the correct amount of employer or employee FICA tax is paid on any remuneration, and the overpayment cannot be adjusted under section 6413(a) (because the overpayment relates to a period with respect to which the return has already been filed), the amount of the overpayment must be refunded as prescribed by regulations.

Section 31.6413(a)-1(b)(1)(i) of the regulations provides that when the employer ascertains that it has paid more than the correct amount of employee tax under section 3101 after the return reporting the payment has been filed, the employer “shall repay or reimburse the employee” if the error is ascertained within the applicable limitations period. However, the employer is exempted from the refund requirement if the overcollection and overpayment to the district director is “made the subject of a claim ... for refund or credit, and the employer elects to secure the written consent of the employee to the allowance of the refund or credit under the procedure provided in [§ 31.6402(a)-2(a)(2)(i)].”

Section 31.6402(a)-2(a)(2)(i) of the regulations provides that every claim for refund or credit of employee tax under § 3101 collected from an employee shall include a statement that the employer has repaid the tax to such employee or has secured a written consent of such employee to the allowance of the refund or credit.

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Refund Claim Procedures Must Be Followed, Continued

Employer's Duty to First Adjust the Employee Portion of FICA (continued)

Section 31.6402(a)-2(a)(2)(ii) of the regulations provides that if the claim relates to employee tax collected in a year prior to the year in which the credit or refund is claimed, the employer must also submit a statement that it has obtained from the employee a written statement (a) that the employee has not claimed refund or credit of the amount of the overcollection, or if so, such claim has been rejected, and (b) that the employee will not claim refund or credit of such amount.

Revenue Ruling 81-310

Revenue Ruling 81-310, 1981-2 C.B. 241, considered whether attempting to secure employee consents to the allowance of refunds in accordance with § 31.6402(a)-2(a)(2)(i) of the regulations would fulfill the employer's duty to first adjust overpaid employee FICA tax so that the employer could claim a refund of the employer portion of FICA. The ruling holds that when the employer notifies its employees of the overpaid employee FICA tax, and requests their consents to its filing a refund claim on their behalf, it has made reasonable efforts to protect their interests. Thus, the employer's request for employee consents should be treated as fulfilling its duty to "adjust" employee overcollection. Likewise, if the employee simply refuses to sign a consent, the employer has satisfied its duty to first adjust the employee portion of FICA.

Summary

A taxpayer may receive a refund of the employee portion of FICA collected in a year prior to the year in which the refund claim is made only if the taxpayer provides a statement that (1) the taxpayer has obtained the employee's consent to the allowance of the refund, and (2) that it has obtained a statement from the employee that the employee has not claimed (or if claimed, the claim has been rejected) and will not claim a refund for such amount. Thus, in the case of a refund claim involving both portions of FICA, prior to approval of the claim, the employer should show that it has obtained the necessary employee consents and statements. If the employer is claiming a refund of just the employer portion of FICA, the employer must provide a statement that it has made reasonable attempts to first adjust the employee's account, which generally means that the employer has notified the employee and requested the employee's consent.

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Refund Claim Procedures Must Be Followed, Continued

Notes

1. Atlantic Department Stores, Inc. v. United States, 557 F.2d 957 (2d Cir. 1977). See also, Rev. Proc. 81-69, 1981-2 C.B. 726.
 2. Fulfilling these requirements is not a jurisdictional requirement; thus, these requirements need not be satisfied at the time the claim is filed. Rather, these requirements are a prerequisite to the IRS being required to pay a refund claim. Chicago Milwaukee Corporation v. United States, 40 F.3d 373; see GCM 38,786 for a discussion of this issue.
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Appendix — 1965 Revocation of the Medical Intern Exception

The legislative history underlying the Social Security Amendments of 1965, Pub. L. No. 89-97 (SSA of 1965), indicates Congress' intent that medical residents be covered under the FICA. Prior to the SSA of 1965, § 3121(b)(13) of the 1954 Code excluded from the definition of employment "service performed as an intern in the employ of a hospital by an individual who has completed a 4 years' course in a medical school chartered or approved pursuant to State law." Section 311(b)(5) of the SSA of 1965 amended § 3121(b)(13) by striking this provision.

In addition to revoking the medical intern exception, § 311 of the SSA of 1965, entitled, "Coverage for Doctors of Medicine," changed the law in two other ways which affected medical doctors. First, § 1402(c)(5) of the 1954 Code was amended to eliminate the exception from the definition of "trade or business" for physician services (for SECA tax purposes). Second, § 3121(b)(6)(C)(iv) of the 1954 Code, which provided an exclusion from the definition of employment for "service performed in the employ of the United States if the service is performed by any individual as an employee included under § 5351(2) of title 5, [U.S.C.], (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government)," was amended to add, "other than as a medical or dental intern or a medical or dental resident in training."

These provisions taken together indicate Congress' intent to create a scheme under which all medical doctors are covered under the social security system, whether or not they are still in training, whether or not they are self-employed, or whether or not they work for the federal government.

With respect to the repeal of the medical intern exclusion, the Senate Report states,

Section 3121(b)(13) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the [FICA], services performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school Section 311(b)(5) amended section 3121(b)(13) so as to remove this exclusion. The effect of this amendment is to extend coverage under the [FICA] to such interns unless their services are excluded under provisions other than section 3121(b)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the Code.

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Appendix — 1965 Revocation of the Medical Intern Exception, Continued

The last sentence makes indirect reference to the exclusion from FICA for services performed for exempt organizations under § 3121(b)(8)(B) of the 1954 Code. That exclusion was repealed by the Social Security Amendments of 1983 (Pub. L. No. 9821). Nothing in the legislative history indicates that Congress believed interns (or residents, who were even further along in their medical careers than interns) were eligible for the student FICA exception.

The Congressional Record also provides some anecdotal evidence that Congress chose to cover interns along with all other medical doctors under the FICA because young doctors and their families need the protection provided by social security. In speaking against a proposed amendment to strike section 311, Senator Ribicoff of Connecticut recounted the following story:

A charming, educated woman of the age of 38 came into my office. She had three young children. She had married a young man while he was still in medical school. Her husband had just about reached the stage at which he had gone through an internship, through a residency, and had gone out to the State of Oregon to begin the practice of medicine. He died within a year. The young doctor was indebted because of borrowing to open his practice. He left his widow without a nickel.... I believe that we have a problem concerning the coverage of doctors, and that we, as Senators, owe an obligation to the wives and children. We should not seek to exclude them from the coverage of social security.

111 Cong. Rec. 16106 (1965).

Congress' repeal of the medical intern exception in conjunction with the legislative history evidences its concern that young doctors be covered under social security. To apply the Student FICA exception broadly to all resident services would have the effect of overriding the repeal of the medical intern exception under § 3121(b)(13).

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Exhibit 4

Program Requirements for Residency Education in Internal Medicine

- I. Introduction
- II. Institutional Organization
- III. Program Director and Faculty Qualifications and Responsibilities
- IV. Facilities and Resources
- V. Educational Program
- VI. Evaluation
- VII. Certification

I. Introduction

A. Definition and Scope of Specialty

Internal medicine is the discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, and treatment of men and women from adolescence to old age, during times of health and through all stages of acute and chronic illness. Intrinsic to the discipline are the application of the scientific method of problem solving, decision making, and an attitude of caring driven by humanistic and professional values. The practice of internal medicine requires comprehensive knowledge of human biology, behavior, and spirit; an understanding of the epidemiology and pathophysiology of disease; and the mechanisms of treatment. Internal medicine requires a mastery of clinical skills in interviewing, physical examination, differential diagnosis, diagnostic testing strategies, therapeutic techniques, counseling, and disease prevention.

B. Duration and Scope of Education

1. An accredited residency program in internal medicine must provide 36 months of supervised graduate education.
2. The educational program must include core clinical experiences in general internal medicine, the subspecialties of internal medicine, and other specialties. The clinical settings in which these experiences occur must include a minimum of one-third of the time in ambulatory sites and a minimum of one-third of the time in inpatient sites. Over the 36 months of training, at least ½ day each week must be spent managing a panel of general internal medicine patients in continuity.
3. The program must include a schedule of prescribed learning experiences accomplished through teaching rounds, conferences, lectures, and discussions, that ensure the residents' mastery of the knowledge, skills, and attitudes needed to practice general internal medicine or to progress into a subspecialty, research, or a teaching career in internal medicine. The training program

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must include a written evaluation of clinical competence, medical knowledge, skills, and professional attitudes throughout the educational experience.

4. The internal medicine component of special educational tracks must be conducted under the auspices of the Department of Internal Medicine. Although such tracks may differ in educational content, the core experience of residents must provide training in both inpatient and ambulatory general internal medicine to enable the graduates of such special tracks to function as general internists. The Residency Review Committee (RRC) evaluates special educational tracks as part of internal medicine programs in the accreditation process.

II. Institutional Organization

A. Sponsoring Institution

1. Each internal medicine residency must have a single sponsoring institution. It must
 - a. provide an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate and apply research findings, and develop habits of inquiry as a continuing professional responsibility;
 - b. establish the internal medicine residency within a department of internal medicine or an administrative unit whose mission is the advancement of internal medicine education and patient care;
 - c. have an affiliation with a Liaison Committee on Medical Education-accredited medical school, or demonstrate that the primary clinical site has a commitment to education and research similar to that of a medical school;
 - d. have affiliations with community-based institutions, if the sponsoring institution lacks sufficient diversity in faculty, facilities, and resources in the inpatient and/or ambulatory settings;
 - e. provide adequate faculty, resident compensation, facilities, and resources for education, clinical care, and research required for accreditation;
 - f. designate a single program director within the internal medicine administrative unit to lead the internal medicine residency program and its subspecialty residencies at all sites and in all special tracks or combined specialty training with internal medicine; and
 - g. notify the RRC promptly of
 - (1) major changes in leadership, governance, affiliation, or fiscal arrangements that affect the educational program and
 - (2) a change in the program director. The qualifications and the curriculum vitae of the new program director must be submitted to the RRC.

The RRC may schedule a site visit when notified about either of the above changes.

2. A sponsoring institution must not place excessive reliance on residents to meet the service needs of the participating training sites. To this end, the sponsoring and participating institutions must have institutional written policies or procedures that address the following:

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- a. Residents must not routinely be required to provide intravenous, phlebotomy, or messenger/transporter services.
- b. Residents' service responsibilities must be limited to patients for whom the training program bears major diagnostic and therapeutic responsibility.
- c. On inpatient rotations, residents should have continuing responsibility for most of the patients they admit.
- d. Supervision by faculty members must be provided for all patient care activities in which residents are engaged.
- e. Educational experiences must include interactions with attending physicians and other residents, as well as teaching rounds, conferences, evaluation, and formative feedback.
- f. For each rotation or major clinical assignment, the teaching ratio must not exceed a total of 8 residents or students to one teaching attending.
- g. Total required emergency medicine experience must not exceed 3 months in 3 years of training for a resident
- h. Total required critical care experience must not exceed 6 months in 3 years of training for a resident. (NOTE: When elective experience is added in the critical care unit, it must not result in more than a total of 8 months in 3 years of training for any resident)
- i. When averaged over any 4-week rotation or assignment, residents must not spend more than 80 hours per week in patient care duties.
- j. Residents must not be assigned on-call in-house duty more often than every third night.
- k. When averaged over any 4-week rotation or assignment, residents must have at least 1 day out of 7 free of patient care duties.
- l. During emergency medicine assignments, continuous duty must not exceed 12 hours.
- m. Emergency medicine or night float assignments must be separated by at least 8 hours of non-patient-care duties.
- n. During ambulatory assignments, a first-year resident's patient load, on average, must not exceed two new patients or more than six return patients per ½ day session.
- o. On in-patient rotations or assignments (NOTE: These limits may be increased by 2 in special rotations where each admission does not require a full workup, providing it is educationally justified).
 - (1) a first-year resident must not be responsible for more than five new patients per admitting day.
 - (2) a first-year resident must not be assigned more than eight new patient admissions in a 48-hour period.
 - (3) a first-year resident must not be responsible for the ongoing care of more than twelve patients.
 - (4) When supervising more than one first-year resident, the second- or third-year resident must not be responsible for the ongoing care of more than 24 patients.
 - (5) The second- or third-year resident must not be responsible for admitting more than a total of 10 new patients per admitting day or more than 16 new patients in a 48-hour period, which includes the first-year resident's patients being supervised.

B. Participating Institutions

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1. Participation by any institution that provides more than 6 months of the training in the program must be approved by the RRC.
2. When two or more institutions affiliate to participate in residency education, a written agreement, signed by the authorities of each institution, must document the following:
 - a. Purpose and scope of the affiliation for internal medicine residency education
 - b. Financial, faculty, and facility resources involved
 - c. An administrative relationship between the institutions that ensures the program director's authority to accomplish the goals and objectives of the clinical and didactic curriculum at all training sites
 - d. Delegation of the authority and responsibility for the day-to-day program operations at the participating institution to a key faculty member who reports to the program director
 - e. Assurance that residents assigned to all training sites will attend their continuity clinics and core conferences
3. At each participating training site, the program must be provided with the necessary professional, technical, and clerical personnel needed to support the residency.

C. Residents

1. Appointment of residents
 - a. The program must select residents in accordance with institutional and departmental policies and procedures. The program should demonstrate the ability to retain qualified residents by graduating at the end of the residency at least 80% of the enrolled, first-year, categorical residents.
 - b. No resident who has satisfactorily completed a preliminary training year may be appointed to 1 or more additional years as a preliminary resident in that program.
 - c. Before accepting a resident in transfer from another program, the program director should receive a written evaluation of the resident's past performance from the previous program director(s).
2. Resident complement

The RRC will stipulate the maximum total number of residents that can be supported by the educational resources for the program. The program director must obtain approval from the RRC. before changing the number of approved residency positions. (NOTE: The resident complement is the total number of resident positions offered in the 3-year training program. The number includes all preliminary, categorical, and special track residents. For programs that offer combined internal medicine and another specialty training, the number added to the total resident complement is half of the total complement for the full term of the combined training.)
3. Resident advancement

The program director, with participation of members of the teaching staff, must advance residents to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth.

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III. Program Director and Faculty Qualifications and Responsibilities

A. General Qualifications and Responsibilities

1. Qualifications

The program director and all faculty members

- a. must be licensed to practice medicine in the state where the sponsoring institution is located. (Certain federal programs are exempted.)
- b. must have an appointment in good standing to the medical staff of an institution participating in the training program.
- c. should be certified by the specialty board or present equivalent credentials or experience acceptable to the RRC.
- d. must meet professional standards of ethical behavior.

2. Responsibilities

The program director and all faculty members

- a. must have a commitment to the goals and objectives of the teaching program, including development of the residents medical knowledge; clinical, technical, and management skills; and clinical judgment.
- b. should be able to nurture the attributes of the scholar, scientist, teacher, and humanist in residents.
- c. should be available to residents for advice and counseling.
- d. must comply with the written curriculum that describes both patient-based and educational elements of the residency.
- e. should review the written learning objectives and expectations for each rotation or assignment with residents at the beginning of the rotation or assignment.
- f. must be sensitive to the need for timely provision of confidential counseling and psychological support services to residents.
- g. must provide written and verbal feedback to residents at the end of each rotation or assignment.

B. Program Director

1. Qualifications

The program director must

- a. be an institutionally based appointee, i.e., his or her home office must be at the principal clinical training institution. The program director also must bear responsibility to the sponsoring institution.
- b. have at least 5 years of participation as an active faculty member in an accredited internal medicine residency program.
- c. be certified by the American Board of Internal Medicine or present equivalent credentials acceptable to the RRC.

Exhibit 4

2. Responsibilities

The program director

- a. must dedicate the majority of his or her professional effort, i.e., an average of at least 20 hours per week throughout the year, to the internal medicine training program
- b. must be primarily responsible for the organization, implementation, and supervision of all aspects of the training program, including the selection and supervision of the faculty members and other program personnel at each institution participating in the program.
- c. must select residents for appointment to the program in accordance with institutional and departmental policies and procedures, evaluate the quality of care rendered by the residents, have the authority to ensure effective teaching, and obtain teaching commitments from other departments involved in the education of internal medicine residents.
- d. must prepare written learning objectives and expectations outlining the educational goals and objectives of the program with respect to knowledge, skills, and other attributes of residents at each level of training and for each major rotation or other program assignment.
- e. must ensure that the written learning objectives and expectations are readily available for review and are distributed to residents and faculty members.
- f. must ensure that the residency does not place excessive reliance on service as opposed to education. (NOTE: See Section II.A.2. for examples of excessive service.)
- g. must notify the RRC promptly of
 - (1) any change in the number of residents in the training program and
 - (2) major changes in the structure of the educational program.The RRC may schedule a site visit when notified about either of the above changes.
- h. must prepare an accurate statistical and narrative description of the program, as required by the RRC.
- i. must monitor the residents' stress, including mental or emotional conditions inhibiting performance or learning and drug-or alcohol-related dysfunction.
- j. must evaluate and modify training situations that consistently produce undesirable stress on residents.
- k. must be responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation.
- l. must establish and use educational standards that determine the residents' competence in procedures and skills.
- m. should monitor any internal medicine subspecialty training programs sponsored by the institution to ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) accreditation standards.
- n. should ensure that there is a rapid and reliable system for residents to communicate with supervising attending physicians and residents.
- o. must establish a system that ensures that attending physicians are available to participate in the residents' diagnostic and management decisions in a timely manner.
- p. should outline in written policies the lines of responsibility and supervision for the care of patients on all inpatient and ambulatory settings, including all clinical sites for all members of the teaching teams and program staff.

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C. Key Clinical Faculty Members

The residency program must include four institutionally based faculty members, not including the program director and chief residents.

1. Qualifications

Key clinical faculty members must

- a. be certified by the American Board of Internal Medicine or present equivalent credentials acceptable to the RRC.
- b. have documented clinical, academic, and administrative experience to ensure effective implementation of the Program Requirements.
- c. be clinicians with broad knowledge of, experience with, and commitment to internal medicine, whether trained as general internists or as subspecialists.

2. Responsibilities

Key clinical faculty members

- a. must dedicate the majority of their professional effort, i.e., an average of at least 20 hours per week throughout the year, to the internal medicine training program.
- b. should participate in prescribed faculty development programs designed to enhance their teaching effectiveness.
- c. should assist in the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation.
- d. must assist in the preparation of a written curriculum that describes both patient-based and educational elements of the residency and outlines the goals and objectives of the program with respect to knowledge, skills, and other attributes of residents at each level of training and for each major rotation or other program assignment.
- e. must demonstrate that they share with the program director a commitment to the goals and objectives of the curriculum.
- f. must assist in nurturing the attributes of the scholar, scientist, teacher, and humanist in the residents.
- g. must assist in monitoring resident stress, including mental or emotional conditions inhibiting performance or learning and drug-or alcohol-related dysfunction.

D. Other Faculty

1. Qualifications

- a. Qualified individuals (Division Chiefs) must be certified by the American Board of Internal Medicine in their internal medicine subspecialty or present equivalent credentials acceptable to the RRC.
- b. Each division chief should have a term of office to achieve the educational goals and objectives of the residency.
- c. Internal medicine subspecialty support should include adequate professional and teaching staff.

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- d. PhD faculty members not holding an MD may be included as other teaching faculty but they may not be regarded as key clinical faculty members.
2. Responsibilities
 - a. Division chiefs or their designates must be appointed to be responsible for teaching activities in the recognized internal medicine subspecialties.
 - b. Division chiefs must organize, supervise, and implement the clinical and educational subspecialty training as specified in the curriculum.
 - c. Each consultative service must be headed by a qualified individual who ensures that consultants participate in the education of residents on the medical teaching services.
 - d. Supervisors of special educational tracks must report directly to the internal medicine program director.

IV. Facilities and Resources

Modern hospital facilities (i.e., diagnostic, therapeutic, and laboratory) to fulfill the curriculum must be available and functioning. Adequate facilities, support services, and space for outpatient teaching and patient care must be available. Residents must have clinical experiences in efficient, effective ambulatory care settings.

A. Space and Equipment

There must be space and equipment for the educational program, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and office space for teaching staff.

B. Facilities

1. To ensure that a spectrum of cardiovascular disorders is available for resident education, cardiac catheterization facilities should be present at the site(s) where the residents see the majority of their acutely ill, hospitalized patients with a range of cardiovascular diseases. If such facilities are not present, the program must demonstrate that all residents care for patients with a similar range of cardiovascular disorders.
2. Facilities should be available to the program to ensure that residents become proficient in the effective use of current and evolving technologies, that the involved institution(s) has an appropriate patient mix, and that related educational goals and objectives are achieved. These facilities should include but not be limited to those for bronchoscopy; coagulation studies; gastrointestinal motility and endoscopy; noninvasive cardiology studies; pulmonary function studies; hemodialysis; and imaging studies including radionuclide, ultrasound, fluoroscopy, plain films, angiography, computer tomography, and magnetic resonance.
3. Internal medicine subspecialty resources should include specialized laboratory and technical facilities.

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4. Residents must have sleeping, lounge, and food facilities during assigned duty hours. When residents are assigned night duty in the hospital, they must be provided with on-call facilities that are convenient and that afford privacy, safety, and a restful environment. The safety of residents at all times while on duty is essential. Residents must be instructed regarding fire protocols, electrical safety, protocols and dangers relating to hazardous materials, and assault safeguards. Security personnel must be available as necessary.
5. It is desirable that the program use community resources such as physicians' offices, neighborhood health centers, or home-care and/or managed-care facilities to broaden the base of residents' clinical experiences with ambulatory patients.

C. Medical Records

1. A medical records department that facilitates both patient care and residents' education must be available.
2. Clinical records that document both inpatient and ambulatory care must be maintained such that prompt accessibility is ensured at all times.

D. Medical Library

1. A medical library under the direction of a qualified medical librarian must be readily accessible.
2. There must be a means of access to an on-site library or to reference material in each participating institution during those times when the library is not open or staffed.
3. The library must contain a representative selection of books and journals on internal medicine.
4. At all training sites, residents should have access to a computerized literature search system and electronic medical databases.

E. Patient Population

1. Patients must be available in sufficient numbers for training purposes in general internal medicine in inpatient, ambulatory, and other settings.
2. Patients must exhibit a variety of clinical problems to provide broad experience in general internal medicine in inpatient, ambulatory, and other settings.
3. There must be patients of both sexes, with a broad range of age from adolescent to geriatric patients.

Exhibit 4

4. The clinical experience should include opportunities to have exposure to patients of a disadvantaged socioeconomic status.

F. Pathology Material

1. All deaths of patients who received care by residents must be reviewed and autopsies performed whenever possible.
2. Residents should review the gross pathological and/or histological specimens soon after autopsies are performed on their patients and should review the autopsy reports.

G. Support Services

1. Inpatient clinical support services must be available on a 24-hour basis to meet reasonable and expected demands, including intravenous services, phlebotomy, services, messenger/transporter services, and laboratory and radiologic information retrieval systems that allow prompt access to results.
2. At all training sites, medical records, x-ray films, and results of diagnostic studies must be readily available.
3. Consultations from other clinical services in the hospital should be available in a timely manner. All consultations should be by or under the supervision of a qualified specialist.

V. Educational Program

A. Program Goals and Objectives (Written Curriculum)

All educational components of the residency should be related to the program's goals and objectives and set down in a written curriculum. For each rotation or major learning experience, the written curriculum

1. should include the educational purpose; teaching methods; the mix of diseases, patient characteristics, and types of clinical encounters, procedures, and services; reading lists, pathological material, and other educational resources to be used; and a method of evaluation of resident performance.
2. must include all required educational and clinical experiences specified in the Program Requirements.
3. must include the clinical experience in inpatient or outpatient settings.
4. must define the level of residents' supervision by faculty members in all patient care activities.

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5. must integrate medical problems, health promotion, and cultural, socioeconomic, ethical, occupational, environmental, and behavioral issues in most rotations or major learning experiences.
6. must be approved as part of the regular review process by the RRC, along with the program design and/or structure.
7. must include teaching rounds and conferences during which residents
 - a. apply knowledge of the etiology, pathogenesis, clinical presentation, and natural history of the diseases treated by internists to demonstrate skills in diagnosis, mature judgment, and resourcefulness in therapy;
 - b. receive instruction and feedback to master the interviewing, communication, and interpersonal skills that are necessary to elicit and record a thorough and accurate history, establish and maintain a therapeutic physician-patient relationship, and initiate or motivate the patient to implement optimal medical management;
 - c. receive instruction and feedback to develop expertise in physical examination skills that include training in bimanual female pelvic examination, PAP smears, and speculum examination of the vagina; and
 - d. demonstrate the humanistic treatment of patients.
8. must indicate that residents care for patients with a wide range of clinical problems in all stages of illness.
9. should include rotations or assignments during which residents learn to work with other members of the health-care team and learn to become leaders in the organization and management of patient care.
10. should be revised by faculty members and residents to keep it current and relevant.

B. Presence of Other Residents

For each year of training, the percentage of resident-months on those inpatient services used for training internal medicine residents that can be assigned to residents other than those enrolled in internal medicine in categorical (3-year), preliminary (1-year), and special tracks (i.e., primary care, combined internal medicine-specialty training) and transitional-year program residents sponsored by internal medicine must be less than 25%. (NOTE: Excluded entirely from this limitation are residents from any program who receive training in internal medicine on services to which no internal medicine residents at any level of training are concurrently assigned.)

C. Peer Interaction

1. A program must have a minimum of 12 residents enrolled and participating in the training program at all times.

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2. Inpatient rotations must have first-year residents interacting with more senior internal medicine residents in the care of patients.

D. Meaningful Patient Responsibility

1. Each resident must be assigned for a minimum of 24 months to internal medicine inpatient and ambulatory rotations or assignments during which the resident has primary responsibility for patient care. These inpatient and ambulatory assignments must include development of diagnostic strategies, planning, record keeping, order or prescription writing, management, discharge summary preparation, and decision-making commensurate with residents' abilities and with appropriate supervision by the attending physician.
2. On inpatient rotations, second- or third-year residents with documented experience appropriate to the acuity, complexity, and severity of patient illness should be available at all times on-site to supervise first-year residents.
3. Residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner.

E. Progressive Responsibility

1. The program must ensure; with each year of training, that each resident has increasing responsibility in patient care, leadership, teaching, and administration.
2. Residents from other specialties must not supervise internal medicine residents on any internal medicine inpatient rotation.

F. Individual Responsibility

1. During rotations or assignments where meaningful patient responsibility occurs, there must be a resident schedule, including check-out and check-in procedures, so residents will learn to work in teams to ensure proper care and welfare of the patients.
2. The on-call system must include a plan for backup to ensure that patient care is not jeopardized during or following assigned periods of duty.
3. The residency is a full-time responsibility. Activities outside the training program should not interfere with the resident's educational performance.

G. Formal Teaching Program

1. Rounds
 - a. Teaching rounds

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Teaching rounds must be patient-based sessions in which a few cases are presented as a basis for discussion of such points as interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient the appropriate use of technology, and disease prevention.

- (1) Inpatient and ambulatory teaching rounds must be regularly scheduled and formally conducted.
 - (2) In addition to morning report, inpatient teaching rounds must occur at least 3 days of the week for a minimum of 4½ hours per week.
 - (3) Teaching rounds must include direct resident and attending interaction with the patient. The teaching sessions must include demonstration and evaluation of each resident's interview and physical examination skills.
 - (4) Inpatient teaching rounds must include bedside teaching.
- b. Management rounds by the physician of record
- (1) Each physician of record has the responsibility to interact at intervals with his or her patients and to communicate effectively and frequently with the resident staff participating in the care of these patients. It is desirable that this communication be achieved by the physician of record making management rounds on his or her patients at least daily with at least one member of the resident team.
 - (2) To avoid interference with the resident's educational experience, the resident should not be required to relate to excessive numbers of physicians.
 - (3) Although management rounds may offer many educational opportunities they are not to be confused with or to take the place of teaching rounds. Also, management rounds by the physician of record should not interfere with resident work rounds. (NOTE: Work rounds are rounds in which a senior resident supervises a junior resident's patient care activities, without an attending physician present.) Management rounds by the physician of record are not time-specific and should be commensurate with the needs of the patient.
2. Conferences and seminars
- a. Departmental conferences, seminars, and literature-review activities covering both general medicine and the internal medicine subspecialties should be conducted regularly and sufficiently often to fulfill educational goals.
 - b. The conference schedule must have a core conference series dealing with the major topics in general internal medicine (including issues arising in ambulatory and extended care settings) and the internal medicine subspecialties.
 - c. The core conference series should be repeated often enough to afford each resident an opportunity to complete the curriculum.
 - d. Conferences should include information from the basic medical sciences, with emphasis on the pathophysiology of disease and reviews of recent advances in clinical medicine and biomedical research.
 - e. Conferences correlating current pathological material, including material from autopsies, surgical specimens, and other pathology material, with the clinical course and management of patients must be held at least monthly. Faculty members and attending physicians from other disciplines should be involved.

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- f. Conferences should include a journal club that emphasizes a critical appraisal of the medical literature.
 - g. Residents and faculty members should participate in the planning, production, and presentation of conferences.
 - h. It is desirable that each resident attend at least 60% of those conferences designated as required by the program director.
3. Self-assessment
It is desirable that the program director have each resident use prescribed self-assessment techniques as an educational tool for monitoring his or her own progress toward the program's educational objectives. (NOTE: For example, the program director could have residents participate in in-training examinations or self-study courses.)
4. Basic sciences
- a. The basic sciences should be integrated into the daily clinical activities by clearly linking the pathophysiologic process and findings to the diagnosis, treatment, and management of clinical disorders.
 - b. Residents should acquire an in-depth understanding of the basic mechanisms of normal and abnormal human biology and behavior and the application of current knowledge to practice.

H. Specific Patient Care Experiences

1. Experience with ambulatory patients
 - a. At least one-third of the residency training must be in the ambulatory care setting. (NOTE: In assessing the contribution of various clinical experiences with ambulatory patients to the 33% minimum, the following guidelines can be used: ½ day per week assigned to an ambulatory setting throughout all 3 years of training is equivalent to 10%; a 1-month block rotation is equivalent to 3%; 1 full day per week throughout a single year of training is equivalent to 7%. Examples of settings that may be counted toward this requirement are general medicine continuity clinics, subspecialty clinics, ambulatory block rotations, physicians' offices, managed health care systems, emergency medicine, "walk-in" clinics, neighborhood health clinics, and home-care visits.)
 - b. Residents' clinical experiences with ambulatory patients must occur in each of the 3 years of residency training.
 - c. The residents' clinical experiences with ambulatory patients must include first-contact, comprehensive, and continuing care covering a broad spectrum of disease.
 - d. No more than 2 months (6%) of emergency medicine experience will count toward the required ambulatory experience.
 - e. In an ambulatory setting, one faculty member must be responsible for no more than five residents.
 - f. On-site faculty members' primary responsibilities must include the supervision and teaching of residents. On-site supervision as well as the quality of the educational experience must be documented.

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- g. The patient volume in the ambulatory environment must be large enough to provide adequate numbers of new patients. In general medicine settings, patient loads should, on average, be not less than one new patient and not less than three return patients per ½-day session for each resident.
 - h. Residents must be able to obtain appropriate and timely consultation from other specialties for their ambulatory patients.
 - i. There should be services available from and collegial relationships with other health-care professionals such as nurses, social workers, and dietitians.
 - j. Training in ambulatory care of patients should take place in an environment similar to an office practice.
 - k. The residents' clinical experiences with ambulatory patients should include the opportunity to develop diagnostic and therapeutic skills and professional attitudes in the care of general internal medicine patients.
 - l. It is desirable that supervision be provided by physicians experienced in the broad field of general internal medicine. (NOTE: The program director may assign experienced and qualified [i.e., board certified or equivalent] practitioners from other specialties [e.g., family practice] to participate as teachers in the ambulatory setting.)
 - m. It is desirable that block rotations in the ambulatory setting in subspecialty experiences be utilized to increase the residents' ambulatory experience.
 - n. It is desirable that 50% of the ambulatory experience take place in a general internal medicine setting.
2. Experience with continuity ambulatory patients
- a. The residents must have continuing patient care experience (continuity clinic) in an ambulatory care setting at least ½-day each week over each of the 3 years of training. (NOTE: Preliminary year residents are excluded from this requirement.)
 - b. Residents may be excused from attending their continuity clinic when they are assigned to an intensive care unit or to emergency medicine. The continuing patient care experience should not be interrupted by more than 1 month, excluding a resident's vacation.
 - c. The residents' clinical experiences with ambulatory patients must provide residents the opportunity to observe and to learn the natural course of disease.
 - d. During the continuity experience, arrangements should be made to minimize interruptions of the experience by residents' inpatient duties.
 - e. Each resident must have the opportunity to follow patients on a long-term basis. It is desirable that such long-term observation include following patients from the ambulatory to the inpatient environment as well as from the inpatient to the ambulatory environment.
3. Experience with hospitalized patients
- a. It is desirable that 50% of the inpatient experience occur on general internal medicine services.
 - b. There must be a minimum of 6 months of internal medicine teaching service assignments in the first year, and over the second and third years of training combined, a minimum of 6 months of such training.

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- c. Geographic concentration of inpatients assigned to a given resident is desirable because such concentration promotes effective teaching and fosters interaction with other health personnel.
4. Emergency medicine experience
 - a. Internal medicine residents assigned to emergency medicine must have first-contact responsibility for a sufficient number of unselected patients to meet the educational needs of internal medicine residents. Triage by other physicians prior to this contact is unacceptable.
 - b. Internal medicine residents must be assigned to emergency medicine for at least 4 weeks of direct experience in blocks of not less than 2 weeks.
 - c. Residents must have meaningful responsibility for patients, including participation in diagnosis, management, and admission decisions across the broad spectrum of medical and surgical illnesses such that the residents learn how to determine which patients require hospitalization.
 - d. Internal medicine residents assigned to rotations on emergency medicine must have on-site, 24-hour, daily supervision by qualified faculty members.
 - e. The rotations should be conducted in accordance with a written curriculum. Both the written curriculum and the faculty members should be acceptable to the program director in internal medicine.
 - f. Consultations from other specialties should be readily available.
 5. Critical care unit experience
 - a. Residents must participate directly in the care of patients with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units).
 - b. The assignment must have supervision by trained internists with consultation by internal medicine subspecialists and other specialists.
 - c. The assignment must have critical care unit teaching rounds and conferences acceptable to the program director in internal medicine.
 - d. The experience must not be less than 3 months in 3 years of training for any resident.
 - e. The assignment should be conducted in accordance with a written curriculum. Both the written curriculum and the faculty members should be acceptable to the program director in internal medicine.
 6. Subspecialty Experience
 - a. Education in the various subspecialties of internal medicine should be part of the training program and should be gained in both inpatient and ambulatory settings.
 - b. Although it is not necessary that each resident be assigned to every subspecialty, it is important that each resident should have exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties.
 - c. At a minimum, residents should acquire knowledge sufficient to diagnose, follow, and treat patients with common disorders of the various organ systems covered by the internal medicine subspecialties and to recognize those disorders that should be referred to, or managed jointly with, the appropriate subspecialists.

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7. Consultative experience
 - a. Residents should have sufficient knowledge and experience to act, under supervision, as consultants to physicians in other specialties.
 - b. It is desirable that the principles involved in consultation be included in the core conference series.
8. Geriatric medicine
 - a. Residents must have formal instruction and regular, supervised clinical experience in geriatric medicine.
 - b. The written curriculum must include experiences in the care of a broad range of elderly patients.
 - c. Geriatric clinical experiences must be offered. They may occur at one or more specifically designated geriatric inpatient units, geriatric consultation services, long-term care facilities, geriatric ambulatory clinics, and/or in home-care settings.
9. Adolescent medicine
 - a. Residents should be formally instructed in adolescent medicine, which may include the following topics: health promotion, family planning and human sexuality, sexually transmitted diseases (STDs), chemical dependency, sports medicine, and school health issues.
 - b. Structured patient care experiences directed by faculty in advising young patients on these topics is desirable.
10. Gender-specific health care

Residents should receive instruction in the prevention, counseling, detection, and diagnosis and treatment of diseases of women and men's health, as well as opportunities for clinical experience. (NOTE: This can occur in women's health clinics, obstetric or gynecologic clinics, STD clinics, general medicine clinics, urology clinics, or other specialty clinics.)
11. Experiences in other specialties
 - a. Residents should have sufficient experience in neurology, psychiatry, dermatology, medical ophthalmology, otorhinolaryngology, orthopedics, and rehabilitation medicine to become familiar with those aspects of care in each specialty area that are diagnosed and managed by general internists and with those that should be referred to, or managed jointly with, other specialists.
 - b. It is desirable that some of the residents' clinical experiences with ambulatory patients include these specialties.
12. Procedures and technical skills
 - a. Procedures
 - (1) All residents must be instructed in indications, contraindications, complications, limitations, and interpretations of findings; they must develop technical proficiency in performing the following procedures: advanced cardiopulmonary resuscitation, access techniques to obtain venous and arterial blood, abdominal paracentesis, thoracentesis,

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arthrocentesis of the knee, central venous line placement, lumbar puncture, and nasogastric intubation.

- (2) Residents should be instructed in additional procedural skills that will be determined by the training environment, residents' practice expectations, the availability of skilled teaching faculty, and privilege delineation. These procedures may include but are not limited to arterial line placement; bone marrow aspiration; bladder catheterization; elective cardioversion; endotracheal intubation; flexible sigmoidoscopy; pulmonary artery balloon flotation catheter placement; skin biopsy (punch); temporary pacemaker placement; ambulatory electrocardiographic interpretation; treadmill exercise testing, supervision, and interpretation; fitting vaginal diaphragms; topical chemotherapy for external genital warts; endometrial biopsy; and insertion and removal of IUDs.

- b. Interpretative skills

All residents should be given an opportunity to develop competency in interpretation of electrocardiograms, chest roentgenograms, Gram stains of sputum, microscopic examinations of urine, spirometry, and KOH and wet prep examinations of vaginal discharge for clue cells, Candida, and trichomonas.

I. Professional Ethical Behavior

1. Physician accountability

- a. The training program must have mentors, role-model clinicians, and a resident culture that demonstrates the values of professionalism, such as placing the needs of patients first, maintaining a commitment to scholarship, helping colleagues meet their responsibilities, a commitment to continued improvement, and being responsive to society's health-care needs.
- b. Residents should be given the opportunity to participate in community service, professional organizations, and institutional committee activities.

2. Humanistic qualities

Physicians must have the welfare of their patients as their primary professional concern. Thus, the resident, faculty members, and program must demonstrate humanistic qualities that foster the formation of patient/physician relationships. These qualities include integrity, respect, compassion, professional responsibility, courtesy, sensitivity to patient needs for comfort and encouragement, and a professional attitude and behavior toward colleagues. The written curriculum must emphasize the importance of humanistic qualities throughout the residency.

3. Physician impairment

The residency program must instruct residents and faculty members in physician impairment, to include the recognition of, intervention in, and management of impairment such as alcohol and other substance abuse; depression; dementia; and other mental, emotional, and physical disorders in their peers, as well as the principles and methods of active intervention.

4. Professional ethics

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The training program must foster a commitment to professional ethics in residents that is demonstrated by a spirit of collegiality and a high standard of moral and ethical behavior within the clinical setting in the care of patients, in the education of residents, in conducting research, and in interacting with pharmaceutical companies and funding organizations.

J. Special Educational Requirements

1. Clinical ethics

The program must include education in the principles of bioethics as applied to medical care, and the residents must participate in decision making involving ethical issues that arise in the diagnosis and management of their patients.

2. Quality assessment, quality improvement, risk management, and

- a. Residents should receive instruction in the social and economic impact of medical decisions on patients and society and the need to be the primary advocate for patients' needs.
- b. It is desirable that all residents receive formal instruction regarding the principles, objectives, and processes of quality assessment and improvement and of risk management.

3. Preventive medicine

- a. Screening for disease, disease prevention, maintenance of general health, and health promotion should be emphasized in the curriculum.
- b. It is desirable that all residents receive instruction in occupational and environmental disease processes and in methods for their control.

4. Medical informatics and decision-making skills

- a. Residents should receive instruction in the critical assessment of medical literature, in clinical epidemiology, in biostatistics, and in clinical decision theory.
- b. Each resident should receive instruction in basic computer skills. Instruction should include an introduction to computer capabilities and medical applications, basic techniques for electronic retrieval of medical literature, computer-assisted medical instruction, and electronic information networks.

5. Law and public policy

Residents must receive instruction in the basic legal principles inherent in the practice of internal medicine, including issues of informed consent, advance medical directives, "do not resuscitate" orders, organ donation, living wills, patient advocacy, and related state laws concerning patients' rights.

6. Pain management

Each resident should receive instruction in the principles and practice of pain management, including symptom assessment and control.

7. End-of-life care

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- a. Each resident should receive instruction in the principles of palliative care for terminally ill patients, including the role of the health-care team. Instruction should include psychosocial, cultural, and religious issues related to death and dying.
 - b. It is desirable that residents participate in hospice and home care.
8. Principles of managed care
It is desirable that each resident receive instruction in the principles of managed care, including but not limited to the development and use of critical pathways and cost-efficient use of medical resources.
9. Violence
It is desirable that all residents receive instruction in the principles of recognition and management of domestic violence and of sexual, family, and elder abuse.
10. Substance use disorders
All residents should receive instruction in diagnosis and management of alcoholism and other substance abuse. The instruction should include the principles of addiction medicine and interventional techniques. Residents should have clinical experience in managing patients with alcoholism and substance abuse disorders.
11. Sports medicine and school health
It is desirable that all residents receive instruction in the areas of preparticipation sports assessment, injury prevention, evaluative management, and rehabilitation related to athletic and recreational injuries.

K. Research and Scholarly Activities

1. Faculty
The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty members. While not all faculty members must be investigators, key clinical faculty members must demonstrate broad involvement in scholarly activity. Collectively, their activity must include all of the following:
 - a. Active participation in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
 - b. Participation in journal clubs that emphasize a critical appraisal of the medical literature.
 - c. Active participation in regional or national professional and scientific societies.
 - d. Provision of support for resident participation in scholarly activities.
 - e. Regular interaction of residents with clearly identified faculty members (preferably key clinical faculty members)
 - (1) who participate in research conferences that emphasize the presentation of original research.
 - (2) who participate in research that leads to publication or to presentations at regional and national scientific meetings. (NOTE: For example, key clinical faculty member

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participation in original research projects subject to peer review, case reports, or single- or multi-institution clinical trials.)

- (3) who offer guidance and technical support such as research design and statistical analysis to residents involved in research.

2. Residents

Prior to the completion of training, each resident

- a. must demonstrate acceptable scholarly activity such as original research, comprehensive case reports, or review of assigned clinical and research topics and
- b. should have basic science literacy and understand the fundamental principles of clinical study design and evaluation of research findings.

VI. Evaluation

A. Residents

1. Formative evaluation

- a. The program director must evaluate the clinical competence of the residents on a regular basis. The evaluation must include intellectual abilities, clinical skills, interpersonal skills and relationship building, and the development of professional attitudes consistent with being a physician. The resident must be closely observed performing specific tasks of patient management such as the interview and physical examination, choice of diagnostic studies, formulation of differential diagnosis or problem lists, development of plans for short-term and long-term medical management, communication of treatment plans, invasive procedures, and (when on inpatient services) discharge planning. A structured clinical evaluation must be conducted at least once during the first 2 years of the training program for each resident. (NOTE: For example, a mini-clinical evaluation exercise, such as that described in publications by the American Board of Internal Medicine.)
- b. Residents' humanistic qualities must be evaluated by faculty members, peers, and others during all observed clinical encounters.
- c. Chart auditing for format and quality of data entry should be done on a representative sample of resident inpatient and outpatient records (including inpatient discharge summaries) during each rotation, with feedback to the residents. The program director should ensure that the auditing of medical records is incorporated into evaluation components of the program.
- d. Records must be maintained by documentation logbook or by an equivalent method to demonstrate that residents have had experience with invasive procedures. These records must state the indications and complications and include the names of the supervising physicians. Such records must be of sufficient detail to permit use in future credentialing.
- e. Residents must be evaluated in writing and their performance reviewed with them verbally on completion of each rotation period.
- f. Formal evaluations of knowledge, skills, and professional growth of residents and required counseling by the program director or designee must occur at least semiannually.

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- g. Permanent records of the evaluation and counseling process for each resident must be maintained for each resident.
 - h. Such records must be available in the resident's file and must be accessible to the resident and other authorized personnel.
2. Summative evaluation
- a. The program director must prepare an evaluation (e.g., the American Board of Internal Medicine's tracking form) of the clinical competence of each resident annually and at the conclusion of the resident's period of training in the program. Such evaluations stipulate the degree to which the resident has mastered each component of clinical competence (i.e., clinical judgment, medical knowledge, clinical skills, humanistic qualities, professional attitudes and behavior, and provision of medical care) and has acquired proficiency in each of the various procedural skills identified in the program curriculum. They should verify that the resident has demonstrated sufficient professional ability to practice competently and independently.
 - b. A record of the evaluations must be maintained in the program files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in other bodies' actions.
 - c. In the event of an adverse annual evaluation, a resident must be offered an opportunity to address a judgment of academic deficiencies or misconduct before a constituted clinical competence committee.
 - d. There must be a written policy that ensures that academic due process provides fundamental fairness to the resident and protects the institution by ensuring accurate, proper, and definitive resolution of disputed evaluations.

B. Faculty Members and Program

1. Resident evaluation of faculty members and program
- a. The educational effectiveness of a program must be evaluated at least annually in a systematic manner. Specifically, the quality of the curriculum and the extent to which the educational goals and objectives have been met by residents must be assessed. Written evaluations by residents must be utilized in developing programmatic changes.
 - b. The faculty must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them.
 - c. At least one resident representative should participate in these reviews of the training program.
 - d. The faculty should at least annually evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patient available to the program for educational purposes, the performance of faculty members, and the quality of supervision of residents.
 - e. Provision should be made for residents to evaluate the faculty members annually. The results of the evaluations should be used for faculty-member counseling and for selecting faculty members for specific teaching assignments.

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2. Certifying examination
 - a. A program's graduates must achieve a pass rate on the certifying examination of the American Board of Internal Medicine of at least 50% for first-time takers of the examination for the most recent defined 3-year period.
 - b. At least 75% of those completing their training in the program for the most recent defined 3-year period must have taken the certifying examination.

VII. Certification

Residents who plan to seek certification by the American Board of Internal Medicine should communicate with the registration section of the board regarding fulfillment of requirements for certification. Residents must be certified in internal medicine prior to seeking certification in a subspecialty.

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Program Requirements for Residency Education in Diagnostic Radiology

- I. Introduction
- II. Institutional Organization
- III. Faculty Qualifications and Responsibilities
- IV. Facilities and Resources
- V. The Educational Program
- VI. Evaluation
- VII. Board Certification

I. Introduction

A. Definition and Scope

Diagnostic radiology encompasses a variety of diagnostic and image-guided therapeutic techniques, including all aspects of radiological diagnosis, nuclear radiology, diagnostic ultrasound, magnetic resonance, computed tomography, interventional procedures, and the use of other forms of radiant energy. The residency program in diagnostic radiology shall offer a quality graduate medical educational experience of adequate scope and depth in all of these associated diagnostic disciplines.

B. Duration and Scope of Education

Resident education in diagnostic radiology must include 5 years of clinically oriented graduate medical education, of which 4 years must be in diagnostic radiology. The clinical year must consist of Accreditation Council for Graduate Medical Education (ACGME) or equivalent accredited training in internal medicine, pediatrics, surgery or surgical specialties, obstetrics and gynecology, neurology, family practice, emergency medicine, or any combination of these, or an ACGME or equivalent accredited transitional year.

If the clinical year is offered by the institution of the core residency, and it is not itself an ACGME accredited year, the program director will be responsible for assuring the quality of the year. The clinical year should be completed within the first 24 months of training.

The diagnostic radiology program shall offer a minimum of 4 years of graduate medical education (including vacation and meeting time) in diagnostic radiology, of which at least 42 months of training must be in the parent or integrated institution(s). [Note: Time spent attending the AFIP course is excluded.] The minimum period of training in nuclear radiology shall be 6 months. The maximum period of training in any subspecialty area shall be 12 months.

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II. Institutional Organization

All educational components of a residency program should be related to program goals. The program design and structure must be approved by the Residency Review Committee (RRC) as part of the regular review process.

A. Sponsoring Institution

The residency program in diagnostic radiology must have one parent institution with primary responsibility for the entire program. When any institution(s) other than the parent is utilized for the clinical or basic science education of a resident in diagnostic radiology, letters of agreement must be provided by the appropriate institutional authority.

The institution must demonstrate commitment to the program in terms of financial and academic support, including the timely appointment of a permanent department chair.

B. Participating Institutions

Institutions may participate on an affiliated or an integrated basis. An accredited program may be independent or may occur in two or more institutions that develop formal agreements and conjoint responsibilities to provide complementary facilities, teaching staff, and teaching sessions. When another institution is utilized and a single program director assumes responsibility for the entire residency, including the appointment of all residents and teaching staff that institution is designated as integrated. Within a single program some participating hospitals may qualify as integrated, while others are merely affiliated. Rotations to affiliated institutions may not exceed 6 months during the 4 years of training. [Note: Time spent attending the AFIP course is excluded.] Rotations to integrated institutions are not limited in duration. Participation by any affiliated institution providing more than 3 months of training must be approved by the RRC. Prior approval of the RRC must be obtained for participation of an institution on an integrated basis, regardless of the duration of the rotations.

The purpose of another institution's participation and the educational contribution to the total training program shall be denied. Service responsibility alone at a participating institution does not constitute a suitable educational experience. Affiliation shall be avoided with institutions that are at such a distance from the parent institution as to make resident attendance at rounds and conferences impractical, unless there is a comparable educational experience at the affiliated institution.

C. Appointment of Residents

Peer contact and discussion are as important to the learning process as contact with teaching faculty. The number of diagnostic radiology residents in the program must be sufficient to provide for frequent and meaningful discussion with peers as well as to provide appropriate coverage for adequate patient care. Appointment of a minimum of eight residents with, on average, two appointed each year, is required for an efficient learning environment. Prior approval by the RRC is required for an increase in the number of residents.

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The complement of residents must be commensurate with the total capacity of the program to offer an adequate educational experience in diagnostic radiology. A reasonable volume is no less than 7,000 radiologic examinations per year per resident. The number of examinations in each of the subspecialty areas must be of sufficient volume to ensure adequate training experience.

III. Faculty Qualifications and Responsibilities

The program director and teaching faculty are responsible for the general administration of a program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation.

A. Program Director

1. Qualifications of the Program Director

- a. There must be a single program director responsible for the program. The program director must be a faculty member who is a diagnostic radiologist and must contribute sufficient time to the program to fulfill all of the responsibilities inherent in meeting the educational goals of the program.
- b. The program director must have appropriate authority to organize and fulfill administrative and teaching responsibilities to achieve the educational goals of the program. The program director must be licensed to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.)
- c. The program director shall be certified by the American Board of Radiology or possess suitable equivalent qualifications, as determined by the RRC.
- d. The program director also must hold an appointment in good standing to the medical staff of an institution participating in the program. A complete curriculum vitae of the program director shall be filed with the Executive Director of the RRC at the time of appointment and updated with each review of the program by the RRC.
- e. The program director should have sufficient academic and administrative experience to ensure effective implementation of these Program Requirements and should have at least 3 years of participation as an active faculty member in an accredited residency program.

2. Responsibilities of the Program Director

The program director shall be responsible for the total training in diagnostic radiology, which includes the instruction and supervision of residents. The program director shall be responsible for evaluation of the teaching faculty in concert with the department chair.

The program director is responsible for promptly notifying the Executive Director of the RRC in writing of any major changes in the program, including changes in leadership. Prior approval of the RRC is required for the addition or deletion of a major participating hospital,

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for an increase in the number of residents in the program, and for a major change in the format of the program. On review of a proposal for major change in a program, the RRC may determine that a site visit is necessary.

The program director is also responsible for the following:

- a. Preparation of a written statement outlining the curriculum and educational goals and objectives of the program with respect to knowledge, skills, and other attributes of residents at each level of training and for each major rotation or other program assignment. This statement must be distributed to residents and members of the teaching faculty. It should be readily available for review.
- b. Selection of residents for appointment to the program in accordance with institutional and departmental policies and procedures.
- c. Selection and supervision of resident rotations, teaching faculty from the department professional staff, and other program personnel at each institution participating in the program.
- d. Supervision of residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program faculty. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.
- e. Implementation of fair procedures, as established by the sponsoring institution, regarding academic discipline and resident complaints or grievances.
- f. Preparation of an accurate statistical and narrative description of the program as requested by the RRC.
- g. Monitoring of resident stress, including mental or emotional conditions and drug-or alcohol-related dysfunction, inhibiting performance or learning. The program director and teaching faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

B. Faculty

1. All members of the teaching faculty must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, support of the goals and objectives of the program, a commitment to their own continuing medical education, and participation in scholarly activities. There must be a sufficient number of teaching faculty. At a minimum, there must be one full-time equivalent physician faculty member at the parent and integrated institutions for every resident in training, in the program. The teaching faculty must be qualified in those areas in which they are assigned to instruct and supervise residents, and they must contribute sufficient time to the program to provide adequate instruction and supervision.
2. Didactic and clinical teaching must be provided by faculty with documented interests and expertise in the subspecialty involved. The teaching faculty responsible for the training in each designated subspecialty area must demonstrate a commitment to the subspecialty. Such commitment may be demonstrated by any of the following: (1) fellowship training or 3 years

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of subspecialty practice, (2) membership in a subspecialty society, (3) publications and presentations in the subspecialty, (4) annual CME credits in the subspecialty.

3. At least one faculty member must be designated to have primary responsibility for the educational content of each of the nine subspecialty areas. This individual must practice at least 50% of his/her time in the department. The nine subspecialty areas are neuroradiology, musculoskeletal radiology, vascular and interventional radiology, chest radiology, breast imaging, abdominal radiology, pediatric radiology, ultrasonography (including obstetrical and vascular ultrasound), and nuclear radiology. No faculty member can have primary responsibility for the educational content of more than one subspecialty area, although faculty can have clinical responsibility and/or teaching responsibilities in several subspecialty areas. A pediatric radiologist may have a primary appointment at another institution and still be the designated faculty member supervising pediatric radiologic education.
4. A member of the teaching faculty of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.
5. The teaching faculty must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews. The faculty should evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching faculty, and the quality of supervision of residents.

C. Other Program Personnel

Programs must be provided with the additional professional, technical, and clerical personnel needed to support the administration and educational conduct of the program.

IV. Facilities and Resources

- A. The program must provide not only adequate space, equipment, and other pertinent facilities to ensure an effective educational experience for residents in diagnostic radiology but also the modern facilities and equipment required in all of the subspecialty rotations.
- B. There must be 24-hour access to an on-site departmental library or to a collection of journals, references, and resource materials pertinent to progressive levels of education in diagnostic radiology and associated fields in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must include standard diagnostic radiology and radiological subspecialty textbooks and major radiology journals.

Exhibit 4

- C. Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions. The institutional library must have facilities for electronic retrieval of information from medical databases and on-line literature searches.
- D. Service commitments must not compromise the achievement of the program's educational goals and objectives.

V. The Educational Program

A. Clinical Components

The program in diagnostic radiology must provide a sufficient volume and variety of patients to ensure that residents gain experience in the full range of radiologic examinations, procedures, and interpretations. A reasonable volume is no less than 75,000 total radiologic examinations at the parent or integrated program, and no less than 7,000 radiologic examinations per year per resident. The number of examinations in each of the subspecialty areas must be of sufficient volume to ensure adequate training experience. If volume in any subspecialty area is less than acceptable, a plan must be developed to increase trainee exposure. The presence of residents and subspecialty residents from outside institutions for limited rotations should not dilute the educational experience of the core program residents.

The clinical training must provide for progressive, supervised responsibility for patient care and must ensure that the supervised resident performs those procedures commonly accepted in all aspects of diagnostic radiology. The training must include progressive study and experience in all of the diagnostic radiologic subspecialties. The training program should ensure sufficient time to gain experience in neuroradiology, musculoskeletal radiology, vascular and interventional radiology, chest radiology, breast imaging, abdominal radiology, pediatric radiology, ultrasonography (including obstetrical and vascular ultrasound), and nuclear radiology.

Additionally, each resident must have documented supervised experience in interventional procedures, for example, image-guided biopsies, drainage procedures, noncoronary angioplasty, embolization and infusion procedures, and percutaneous introduction techniques.

The program director must require that residents maintain a record (electronic or written) in which they document the performance, interpretation and complications of vascular, interventional and invasive procedures. The record must be reviewed by the program director or faculty designee on a yearly basis.

Training and experience are required in plain film interpretation, computed tomography, magnetic resonance imaging, ultrasonography, angiography, and nuclear radiology examinations related to cardiovascular disease. The program must also provide instruction in cardiac anatomy, physiology, and pathology, including the coronary arteries, as essential to the interpretation of cardiac imaging studies. This training must include both the adult and the pediatric age group.

Exhibit 4

Radiologic education in different organ systems must provide the opportunity for residents to develop adequate knowledge regarding normal and pathologic physiology, including the biologic and pharmacologic actions of materials administered to patients in diagnostic studies.

Each resident must have basic life-support training, and advanced cardiac life-support training is recommended.

B. Didactic Components

The education in diagnostic radiology must occur in an environment that encourages the interchange of knowledge and experience among residents in the program and with residents in other major clinical specialties located in those institutions participating in the program.

Diagnostic radiologic physics, radiation biology, radiation protection, and pathology are required elements of the curriculum. In view of the importance of understanding pathology as a basis for radiologic diagnosis, emphasis should be placed on its study. Radiologic/pathologic conferences are required for those residents who do not participate in formalized extramural pathology teaching programs.

Computer applications in radiology, practice management, and health systems and quality improvement are also required curriculum components.

Teaching files (electronic or film) of cases related to all aspects of diagnostic radiology must be available for use by residents. Aggregates of these files should contain a minimum of 1000 cases that are actively maintained and continually enhanced with new cases. The American College of Radiology learning file or its equivalent should be available to residents; this only partially meets the teaching file requirements.

Conferences and teaching rounds must be correlated and provide for progressive resident participation. There should be intradepartmental conferences as well as interdepartmental conferences of appropriate frequency with each major clinical department in which both residents and faculty participate on a regular basis.

C. Resident Policies

1. Supervision

The responsibility or independence given to residents should depend on their knowledge, manual skill, and experience. Faculty supervision must be available at all sites of training.

The resident in the first year of training in the diagnostic radiology program must have a minimum of 6 months of training in diagnostic radiology prior to independent in-house on-call responsibilities. Residents must always have faculty backup when taking night or weekend call. All radiologic images must be reviewed and all reports must be signed by faculty.

Exhibit 4

2. Duty Hours and Conditions of Work

Duty hours and night and weekend call for residents must reflect the concept of responsibility for adequate patient care. However, residents must not be required regularly to perform excessively difficult or prolonged duties. It is recommended that residents should be allowed to spend at least 1 full day out of 7 away from the hospital and should be assigned on-call duty in the hospital no more than, on average, every third night. It is the responsibility of the program director to monitor resident assignments to ensure adherence to this recommendation.

D. Other Required Components

1. Scholarly Activity

Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the teaching faculty. While not all members of a teaching faculty must be investigators, the faculty as a whole must demonstrate broad involvement in scholarly activity. This activity should include

- a. active participation of the teaching faculty in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
- b. participation in journal clubs and research conferences.
- c. active participation in regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publication in their journals.
- d. participation in continuing medical education programs.
- e. participation in research, particularly in projects that are funded following peer review and/or result in publication or presentations at regional and national scientific meetings.
- f. offering of guidance and technical support (e.g., research design, statistical analysis) for residents involved in scholarly activities.

2. Resident Research

During their training, all residents should be encouraged to engage in an investigative project under faculty supervision. This may take the form of laboratory research, clinical research, or the retrospective analysis of data from patients, and results of such projects shall be suitable for publication or presentation at local, regional, or national scientific meetings.

VI. Evaluation

A. Resident Evaluation

Exhibit 4

The program director is responsible for regular evaluation of residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician. Evaluations of each resident's progress and competence should be conducted preferably at the end of each rotation, but not less than four times yearly. The evaluation must concern itself with intellectual abilities, attitudes and character skills, and clinical and technical competence. The program director or the program director's designee must meet with all the residents at least semiannually to discuss these evaluations and provide feedback on performance. More frequent reviews of performance for residents experiencing difficulties or receiving unfavorable evaluations are required. There must be provision for appropriate and timely feedback of the content of all evaluations to the resident. Residents should be advanced to positions of higher responsibility only on the basis of their satisfactory progressive scholarship and professional growth. The program must maintain a permanent record of the evaluation and counseling process for each resident. Such records must be accessible to the resident and other authorized personnel.

There must be a written final evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation should be part of the resident's permanent record maintained by the institution.

B. Faculty and Program Evaluation

The program must provide the opportunity for residents to provide written confidential evaluation of the faculty and the program at least annually. Each faculty member must review his or her evaluations.

The educational effectiveness of a program must be evaluated in a systematic manner. In particular, the quality of the curriculum and the extent to which the educational goals have been met by residents must be assessed. Anonymous written evaluations by residents should be utilized in this process.

VII. Board Certification

The RRC will consider the performance of a program's graduates on the examinations of the American Board of Radiology as one measure of the quality of the training program. During the most recent 5-year period, at least 50% of its graduates should pass without condition the written and oral examinations on the first attempt.

Residents who plan to seek certification by the American Board of Radiology should communicate with the Executive Director of the Board to be certain of all requirements, including duration of training, for admission to the examination process.

Exhibit 4

ACGME: June 22, 1998 Effective: July 1, 1999

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Auditing Techniques for Medical Resident FICA Claims

I. INTRODUCTION

On July 6, 1998, the Eighth Circuit Court of Appeals held that the University of Minnesota¹ was not required to withhold or pay FICA taxes on the stipends it paid to its medical resident employees. The court concluded that the University's medical residents were not intended to be included within any coverage group as specified in the State of Minnesota's § 218 agreement with the Social Security Administration.

In addition, the court ruled that the medical residents met the Social Security Act's general student exclusion pursuant to § 210(a)(10) because the residents (1) were enrolled at the University, (2) paid tuition, and (3) were registered for approximately fifteen credit hours per semester. These were the only "student" facts discussed by the court in concluding that the primary purpose for the residents' participation in the University's residency program was to pursue a course of study rather than to earn a livelihood.

This decision has resulted in many FICA tax refund claims from employers of medical residents. These employers have concluded that the State of Minnesota decision supports the proposition that all medical residents meet the student FICA exception as provided under Internal Revenue Code § 3121(b)(10). Although State of Minnesota is a Social Security case, § 210(a)(10) of the Social Security Act contains language identical to that in § 3121(b)(10). These employers may assert that their residents are similarly situated to the University of Minnesota, when, in fact, there may be important differences.

Whether the student FICA exception applies in any case depends on the facts and circumstances. A facts and circumstances approach will not be an easy one, especially if the auditor immediately begins the audit by attempting to review each and every residency program of the employer. Most of the residency programs are quite large; many institutions have programs with over 1,000 residents within 80 – 100 different specialty programs. Therefore, the following techniques have been designed to guide the audit process from the easiest, least time-consuming techniques down to the most difficult, more time-consuming techniques, which should result in a more efficient and effective audit process.

¹ State of Minnesota v. Apfel, 151 F.3d 742 (8th Cir. 1998).

Exhibit 5

II. AUDIT TECHNIQUES

A. Review the Claim

1. Make sure that the claim has been timely filed; i.e. it must be filed within:
 - 3 years from the time the return was originally filed, or
 - 2 years from the time the tax was paid,whichever of such periods expires later.² Remember the April 15 special statute rule for FICA tax.³
2. Determine the dollar amount involved and the number of residents included within the claim.
3. Review the supporting schedules, if included in the claim.
4. Verify that the claim is based on the student FICA exception under IRC § 3121(b)(10).

B. Determine General Information About the Residency Program

The agent should determine:

1. The type and duration of the residency programs at issue in the claim by specialty and subspecialty;
2. the number of residents within each type specialty and subspecialty; and
3. whether rotations are performed at participating institutions in connection with any of the programs and the duration of any such rotations.

Secure an organizational chart to assist with this review. This chart should show all of the entities involved with the residency program.

Many institutions have their own websites that may be visited to secure additional details about their residency programs.

The American Medical Association maintains a website called FREIDA (Fellowship and Residency Electronic Interactive Database Access) online. This site may be visited to secure

² See IRC § 6551(a).

³ See IRC § 6513(c) which indicates that with respect to social security taxes and income tax withholding, a return filed or tax paid before April 15 of the succeeding calendar year is considered filed on April 15 of such succeeding calendar year.

Exhibit 5

specific sponsoring institution information for all accredited residency programs. It may be accessed at: <http://www.ama-assn.org/cgi-bin/freida/freidac.cgi>.

C. Determine Who the “Employer” Is

The common law employer must be identified. Section 31.3121(b)(10)-2(c) of the Employment Tax Regulations provides that “the status of the employee as a student performing the services shall be determined on the basis of the relationship of such employee with the organization for which the services are performed.” Thus, the identity of the common law employer is essential to determining whether the exclusion under § 3121(b)(10) applies because the common law employer must be a school, college or university (S/C/U). Identifying the common law employer is also essential to determining whether the resident is covered by a § 218 agreement (discussed below).

The common law employer is the person that has the right to direct and control the employee. **The training materials provide a list of documentary evidence that will likely be relevant in developing the facts regarding direction and control.**

1. The fact that a medical resident is on the payroll of a medical school does not mean that the medical school is the employer. Identify for which entity the residents are performing their services to identify the common law employer.⁴
2. Review the relationship of the resident with the institution where the services are performed. For example, who determines the residents’ on-duty and on-call work hours? In addition, review the terms of any affiliation agreements between the sponsoring institution and the participating institution(s).

See the training materials regarding developing the facts on behavioral control, financial control, and the relationship of the parties.

D. Section 218 Agreements

1. If the employer is a state or local government, review terms of the state’s § 218 agreement to determine if medical resident employees are in a “coverage group.” A coverage group consists of individuals who perform services that are included under an agreement entered into pursuant to § 218 of the Social Security Act. If they are in a coverage group, then determine if the state has chosen to exclude students from the coverage group. If the taxpayer is a state or local government entity, the refund claim may contain information regarding § 218 agreement coverage.

⁴ Refer to Rev. Rul. 87-41, 1987-1 CB 296 and IRS Training Document 3320-102, “Independent Contractor or Employee” for additional guidance on determining the employer.

Exhibit 5

See the training materials regarding section 218 agreements. See also the list of State Social Security Administrators, who can assist in determining whether the employer participates in the state's § 218 agreement.

E. The Employer Must Be a S/C/U or § 509(a)(3) Organization

1. The residents' services must be performed in the employ of either a:
 - > school, college, or university⁵, or
 - > an organization described in § 509(a)(3).
2. The Employment Tax Regulations provide that the term "school, college or university" is to be construed in its "commonly or generally accepted sense."⁶ If the employer is recognized as a tax-exempt § 501 (c)(3) organization that is further described within § 170(b)(1)(A)(ii) as an "educational organization," no further review is generally warranted; accept the employer as a S/C/U.
3. Status as a college or university is easily identifiable. Identifying the status of a school will be more difficult. The dictionary definition of a school is "an institution or academic department for teaching in a particular field; a systematic program of studies; the activity of teaching or of learning under instruction; the body of pupils or followers of a master, system, method, etc."⁷
4. It may be helpful to review the articles of incorporation, by-laws, and Form 1023, "Application for Recognition of Exemption," to ascertain the employer's stated exempt purposes. Review the Form 990, Part III, "Statement of Program Service Accomplishments," for additional insight into the organization's exempt purpose.
5. On the other hand, a "hospital" will generally not meet the commonly or generally accepted sense of the term "S/C/U." However, see the § 509(a)(3) discussion immediately following.

F. A § 509(a)(3) Supporting Organization

1. An organization that supports a S/C/U does not need to be formally classified as a § 509(a)(3) organization by the IRS; it merely needs to be "described in" § 509(a)(3). Review the organizational composition of the common law employer that claims to have § 509(a)(3) status (in lieu of separate S/C/U status). Review the articles of incorporation and by-laws to verify that the organizational test has been met. Review activities to verify

⁵ For purposes of the student FICA exception, the statutory test is to determine the "character of the organization in the employ of which the services are performed as a school, college, or university...." Regs. § 31.3121(b)(10)-2(b).

⁶ Regs. § 31.3121(b)(10)-2(d).

⁷ The Random House College Dictionary, Revised Edition, 1982.

Exhibit 5

that the “operated exclusively” test has been met. See the discussion in the training materials regarding § 509(a)(3) organizations.

2. Refer to Regs. §§ 1.509(a)-4(f), (g), (h), (i) and (j) for further information on the § 509(a)(3) requirements (i.e., the exclusive benefit of, to perform the functions of, or carrying out the purposes of tests and the operated, supervised, or controlled by or in connection with test).

G. Student Status

1. If the common law employer has passed all of the tests so far, the medical resident’s status as a student should then be explored. The Code and Regulations do not define the term “student.” A dictionary definition of a student is a “person formally engaged in learning, especially one enrolled in an institution of secondary or higher education” and “any person who studies, investigates, or carefully examines a subject.”⁸
2. All accredited programs will have an educational program. The educational program requirements of the accrediting body should be determined. In addition, the residency program may have additional educational program requirements. Information should be requested from the taxpayer regarding the educational program requirements for the residency programs that the agent has chosen to examine. The training materials contain examples of ACGME educational program requirements. Note how the program requirements vary by type of residency program.
3. In State of Minnesota, the court noted three facts to support its conclusion that the medical residents at the University of Minnesota were students within the meaning of § 210(a)(10) of the Social Security Act. The University’s residents were (1) enrolled at the university, (2) paid tuition, and (3) were registered for approximately 15 credit hours per semester. In the court’s view, these three factors indicated student status. Although these are relevant facts, there are other relevant facts that should be developed in determining student status. **See the training materials for additional facts to be developed with respect to student status.** With respect to each residency program that has been selected for examination, the agent should ask the employer if all of their resident employees meet these three requirements and, if so, how. In this regard, determine if the residents pay tuition and/or other student fees and how such amounts are calculated. If no tuition is charged, determine why not. Do other “students” pay tuition? How many credits do the residents typically register for each quarter, semester, or other period? What is the minimum number of credits they must be registered for? If the residents are not registered for credits, determine why not. In addition, the other facts on student status described in the training materials should also be developed.
4. Regularly attending classes. The plain language in the statute of the student FICA exception requires that the student who is enrolled at a S/C/U must also be “regularly

⁸ The Random House College Dictionary, Revised Edition, 1982.

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attending classes at such school, college, or university.” Determine whether the resident receives instruction in a formal classroom environment. Certain activities may be viewed as the equivalent of classroom training such as formal rounds and training seminars. The most relevant consideration is whether a faculty member plays a leadership role in furthering the objectives of an established curriculum. **See the training materials discussion on this topic.** Most residency programs require a classroom training component in conjunction with an on-the-job training component. Determine if the classroom training component declines as the resident proceeds through his/her program. Compare the time spent in educational activities with the time spent on duty performing patient care services that are not part of a formal training experience within the program’s educational program. If circumstances change so that the educational activities are no longer “regular,” the resident would no longer be eligible for the student FICA exception.

5. The agent should then determine which of these taxpayer-identified specialties and subspecialties to pursue further, concentrating on those programs with the largest numbers of residents within them. The following specialties will likely meet this standard: Family Practice, Internal Medicine, Pediatrics (three-year programs); Obstetrics/Gynecology, Radiology, Pathology (four-year programs); General Surgery (five-year program). In addition, one or more of the following subspecialties should be reviewed: Internal Medicine, Pediatrics, General Surgery (six to seven-year programs). At this point the audit process will become much more focused on the facts and circumstances.