UNIVERSITY OF HAWAIʻI SYSTEM
Legislative Testimony

Written Testimony Presented Before the
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House on Health

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SB 2207 - RELATING TO MEDICAL RESIDENCY

Aloha, Chair Ige, Vice Chair Green and members of the Senate Committee on Health. Thank you for this opportunity to testify in opposition of Senate Bill 2207, which allows medical residents who are licensed to practice medicine in the State to practice medicine outside of their medical residency program hospitals or clinics.

As the Dean and Associate Dean for Clinical Affairs at the John A. Burns School of Medicine (JABSOM), we are directly involved in the planning and oversight of the medical school and the graduate medical education (GME) programs in Hawaiʻi. The Accreditation Council on Graduate Medical Education (ACGME), the national accreditation body for all residency and fellowship programs, requires that all programs have an Institutional Sponsor. JABSOM serves in that capacity, working collaboratively with Hawaiʻi Residency Programs (HRP) to assure excellence in education and full accreditation of our programs. It is important to remember that in order for a resident to become board certified in any medical specialty, he or she must graduate from an ACGME accredited residency program.

We have had the opportunity to review SB2207 and, although we appreciate that the intent is to address physician workforce shortages which are real and growing worse daily, we do not believe that mandating unsupervised resident moonlighting will serve that purpose well. Instead, we are concerned that this bill could compromise the accreditation of our current programs and thus negatively impact one of the most reliable sources of physicians in Hawaii.

Our goal today is to provide you with relevant historical and regulatory background regarding resident work hours and supervision. Our hope is that this information will help you understand why those of us responsible for resident education oppose this particular solution. We would ask that this bill be set aside so we can then focus on viable long term solutions to the workforce crisis.

On March 5th, 1984 an 18 year old named Libby Zion was admitted to Cornell Medical Center. Within 8 hours of arrival, and while under the care of an intern and resident, she died. Her father was a journalist at the New York Times. In the very public legal turmoil that followed several issues were raised regarding resident workload, work hours, and supervision. The Bell Commission reviewed the impact of these factors on patient safety and recommend limits be set to avoid risk due to fatigued physicians. New York State responded in 1989 with legislation to limit work hours and shift lengths. The ACGME recommended similar guidelines for residencies in the mid 1990's but many programs did not follow these voluntary guidelines. In 2003, the ACGME published clear regulations and mandated that all programs follow them or risk losing accreditation. The Institute of Medicine has been actively studying the impact of workload on patient safety and has recently recommended even more stringent guidelines.

ACGME Duty Hours regulations currently state:

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to

patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences.

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

Residents must have one day in every seven free from clinical responsibilities.

Clearly, even with these guidelines, our residents and fellows continue to work very hard. To meet these new guidelines, hospitals and residency programs all over the country are struggling to balance the demand for patient care, the need to be exposure to a wide variety of cases, and workload.

Since these regulations were created, JABSOM and HRP have worked with sponsoring hospitals in Hawaii to reorganize clinical services and coverage models. This process required additional resources to cover clinical responsibilities while working within these regulations. The impact of this has been borne fiscally by hospitals currently sponsoring residency programs and our faculty who often work longer hours to allow residents to work within the limits. Despite these efforts, we have been cited in recent years for exceeding these guidelines as residents and faculty continue to work to identify practical ways to assure care and compliance.

A substantial effort is required in order to monitor and enforce these regulations. HRP surveys 10% of the residents every month to detect issues. Each program surveys all of its residents weekly. The ACGME surveys all the residents every year. Every potential violation requires a full assessment and proposed remedy report to our Graduate Medical Education Committee. Any report that appears to involve a system issue must result in documented action which will then be assessed by the program and reviewed by ACGME.

It was in this setting that we chose to eliminate moonlighting. With growing evidence of the impact of fatigue on safety and the development of clear national standards, we found it difficult to condone the limitation work hours that are supervised while turning a blind eye to unsupervised activities outside of the program. In 2007 our policy was revised to prohibit moonlighting by residents (those post-graduate trainees who are doing their basic specialty training), but not fellows (those doing subspecialty training after their residency), given program director approval. This action was taken to optimize resident clinical training in local hospitals that are organized to provide appropriate supervision. This policy is communicated to residents in advance of their choosing Hawaii and is now part of their employment contract.

We have been advised that the ACGME is considering prohibiting moonlighting in <u>all</u> residencies. Our next major ACGME Site Visit will likely occur in the next 6 months.

In closing, we believe that mandating unsupervised resident moonlighting (SB2207) would impact patient safety, create substantial administrative work to monitor compliance with current regulation and compromise our accreditation with the ACGME. We ask that it be set aside so we can focus on other long term solutions to the growing physician shortages.

We thank you for your time and attention.