SB2207

UNIVERSITY OF HAWAI'I SYSTEM
Legislative Testimony

Written Testimony Presented Before the
House Committee on Higher Education,
House on Health

February 3, 2010, 3:00 p.m.

By

Virginia S. Hinshaw, Chancellor

And

Jerris R. Hedges, MD, MS, MMM
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Barry & Virginia Weinman Endowed Chair
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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 Hawai'i. 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 Hawai'i 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 all 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.

Written Testimony

SB 2207
Relating to Medical Residency
Senate Committee on Health
Senate Committee on Consumer Protection
Public Hearing – February 3, 2010
3:00pm State Capitol, Conference Room 016

By
Lawrence Genen, M.D.,M.B.A.
Psychiatry Resident, PGY2
John A. Burns School of Medicine
University of Hawaii
Department of Psychiatry

I would like to submit the following testimony in strong support of bill SB 2207. In order to appreciate the intent, specifics and substantive progress that this bill represents with regard to improving access to healthcare for Hawaii's citizens I believe it is critical to put this bill into the context of the real world.

This bill directly affects the state of healthcare in Hawaii and is intended to redress an egregious employment practice. And it directly impacts me as I am currently a physician in the state of Hawaii, licensed by the State to practice medicine. I am also a member of the general psychiatry residency program and am employed by Hawaii Residency Programs, Inc., also known as HRP.

In brief, although I am a licensed physician in Hawaii, my current employment agreement prohibits me from practicing medicine whether I get paid or volunteer my services. The vast majority of physicians who choose a career path in medicine have a lifelong history of volunteerism. Yet right when we finally acquire a recognized, standardized competency in the practice of medicine, as reflected by our license to practice medicine by the State of Hawaii – right when we are at the precipice of putting our hard-earned skills to use for the benefit of patients, we are contractually prohibited from even volunteering to treat patients unless it is done at HRP's behest and for the benefit of their member hospitals. How is that even possible?

Well here's the context and current situation.

The Physician Shortage

According to the Rural Health Disparities in Hawaii and Telepsychiatry Report prepared by the Department of Psychiatry , John A. Burns School of Medicine, University of Hawaii at Manoa, by authors including 'Iwalani R.N. Else, Ph.D., Jane Chung-Do, M.P.H, Michelle L. Horton, B.Ed., Daniel Alicata, M.D., Anthony Guerrero, M.D., Michael Fukuda, M.S.W., Chad Koyanagi, M.D., Stephanie T. Nishimura, Ph.D.

"Individuals who live in Hawai'i rural areas can be expected to wait between 1½ months to 3 months to see a physician (Withy, 2008). Due to living in rural areas, individuals may need to request time off from

work in order to visit physicians and may experience issues relating to transportation (e.g., lack of public transportation) (Crisanti, 2003; Withy, 2008).

There is a shortage of practicing physicians on the neighbor islands. Twenty percent of the physicians in Hawai'i were located on the neighbor islands (Sakamoto, 2007)."

[Our neighboring islands have significant access issues.] Hawai'i County encompasses the entire island of Hawai'i and includes the areas of Hilo, Puna, Kau, Hamakua, Kona, and Kohala. These areas are medically underserved areas or populations (Hawai'i Primary Health Care Association, 2006). Accessing health care in Hawai'i county is difficult and residents experience a higher prevalence of chronic illnesses (Grandinetti, Chang, Mau, et al., 1998). There are 23,084 residents in Hawai'i county enrolled in Medicare.

Individuals living in the rural areas are also more likely to experience poor health which includes access issues (i.e., having a qualified health care individual provide health care), issues relating to the inability to afford health care (e.g., uninsured and impoverished), and comorbid health issues (e.g., more likely to experience problems with substance use and other mental health conditions) (Pobutsky, Pordell, Yamashita, et. al., 2004). Nine percent of primary care physicians in the state practice on the island of Hawai'i (Sakamoto, 2007), indicating great need (see Figure 6).

A copy of this report available for committee members.

Role of HRP

After medical school, newly minted medical doctors typically pursue further training known as residency. This residency training enables physicians to pursue specialized training and ultimately enables them to become board-certified in a particular area, such as surgery, internal medicine, pediatrics and psychiatry among many specialties.

In Hawaii all physicians pursuing this additional training through a residency program work for Hawaii Residency Programs, Inc., except for physicians in training affiliated with the military. HRP subsequently has an effective monopoly on the supply of physicians engaged in residency programs. In Hawaii as in other states, in order to become a licensed physician, residents must pass standardized exams and complete the 1st year of their residency, also known as an internship. Additionally it is a requirement of the residency programs here in Hawaii that residents successfully pass all of these licensing exams by the middle of their 2nd year as a resident to remain employed with patient care privileges. Thus the majority of all physicians engaged in residency training, and employed by HRP are licensed or eligible to be licensed physicians.

Hawaii Residency Programs, Inc. is a non-profit organization through which funds for the reimbursement of these resident physicians is funneled by a handful of participating hospitals as well as the State of Hawaii. HRP's Federal EIN is 99-0215841.

Why should you or any of us care at all about HRP? Why should taxpayers care about HRP's employment policies? Well HRP is partly funded by the taxpayers of Hawaii, through the State of

Hawaii's Department of Health. According to the publicly available 2007 year end 990, HRP, a 501c3 organization, earned $16.9 million in program service revenue. Consistent with prior years in FY2007 the State of Hawaii's Department of Health contributed almost 10% of program service revenue. In 2007 Hawaii's taxpayers paid HRP over $1.2million. Member hospitals contributed the vast majority of revenue, at slightly over 90% and the University of Hawaii whose leadership has submitted testimony in this matter, contributed 1% of revenue to HRP in 2007 at less than $175K.

So the taxpayers of Hawaii are providing significant funding to HRP.

The best explanation of the intended purpose of HRP, comes directly from HRP's own filed and publicly available statements. HRP's 2007 Self Dealing Statement Line Number 2c contained within their 2007 Form 990, states: Resident doctors enrolled in graduate medical education are assigned to member hospitals for their medical and surgical training rotations. The member hospitals (remember this concept, member hospitals). The member hospitals are then billed by the organization in order to reimburse it for the actual cost of providing this training support, which cost includes the salary and administrative expenses incurred related to these resident doctors' training rotations.

Additionally, according to Hawaii Residency Programs, Inc., August 16, 2007 Amended and Restated Articles of Incorporation, Article III, HRP's Corporate Purposes. HRP is organized exclusively for the following purposes:

- **To provide better medical care for the people of Hawaii by the advancement of medical education and training for medical residents in the State of Hawaii.**
- Subject to the restrictions set forth in Section 3.2, to engage in any other activities in which a nonprofit corporation organized under Hawaii law may lawfully engage, and
- To operate exclusively for charitable, scientific, literary, religious or educational purposes, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

So HRP, my employer, is a nonprofit organization, funded by the taxpayers of Hawaii and HRP's stated purpose is to **provide better medical care for the people of Hawaii by the advancement of medical education and training for medical residents in the State of Hawaii.**

<u>HRP's Restrictive Employment Practices</u>

So like almost all resident physicians in Hawaii I am employed by HRP. According to the standard employment agreement which governs my employment and that of my colleagues, HRP has placed some serious restrictions on mine and my colleagues' ability to work or even volunteer our services as licensed physicians to citizens in Hawaii that are patients outside of HRP's member hospitals.

Clause. 5. Other Employment of HRP's standard employment agreement states:

> "During the term of this agreement, the Resident shall not accept or receive any fees from any patient, physician, organization, institution or agency for services performed under the auspices of HRP. Further the resident shall not accept any employment outside the Program, for pay or **ON A VOLUNTARY BASIS**, regardless of whether done during duty hours, non-duty hours, or

> while on vacation, paid leave of absence, or unpaid leave of absence, or engage in activities which give the appearance of moonlighting or the appearance that Resident is available to practice medicine other than in the course and scope of residency training. Resident shall not represent, imply or indicate in any way during the term of this Agreement that Resident is available to or can perform the practice of medicine except as an employee of HRP in furtherance of this Agreement. Any violation of this provision constitutes a violation of this Employment Agreement **and may result in termination**."

So HRP is a taxpayer funded nonprofit organization which has an effective monopoly on the supply of physicians engaged in residency programs in Hawaii. According to their own statements they are organized for the purpose of providing better medical care for the people of Hawaii. Yet, HRP restricts the majority of its employees who are licensed physicians from working for hospitals that are non-member hospitals. HRP prevents physicians not only from working for other hospitals in Oahu that aren't lucky enough to be member hospitals like Castle Medical Center among others but prevents licensed physicians from working at neighboring island hospitals, which are not member institutions, perpetuating the physician shortage on our neighboring islands.

Objections to SB 2207

This is an egregious situation that passage of SB 2207 would simply redress. You will hear a variety of objections to why SB 2 207 doesn't work and doesn't make sense. I have heard many as I have unsuccessfully attempted to work in concert with my colleagues and faculty to redress this situation internally through HRP. I believe the objections are simply excuses that ignore today's economic realities. These objections are based on spurious assumptions which ignore the actual facts and most importantly these excuses ignore the needs of Hawaii's citizens and enable a nonprofit organization to exert disproportionate control over the valuable physician workforce at the expense of the majority of Hawaii's residents, for the benefit of a few member hospitals.

I think it is worthwhile to review some of these objections as mentioned in other written testimony I have been informed has been submitted to this committee.

According to this testimony, "we believe that mandating unsupervised resident moonlighting (SB 2207) would impact patient safety [by having unmonitored duty hours], create substantial administrative work to monitor compliance with current regulation and compromise our accreditation with the ACGME."

I respectfully disagree with these assertions.

For starters there is nothing about SB 2207 which "mandates moonlighting". SB 2207 provides licensed physicians with the choice to provide patient care for pay or to volunteer their medical services. Again it is a choice. This characterization of residents practicing medicine as unsupervised and its implication that this is bad or unusual is also simply wrong. Ignoring the employment restrictions placed on us by HRP, once you are licensed by Hawaii's Medical Board, you are licensed to practice medicine without supervision.

The assertion that residents who are licensed physicians would impact patient safety is a very troubling statement. Although physicians are deemed competent to practice medicine by Hawaii's State Medical Board, this testimony objecting to SB 2207 seems to imply that these newly licensed physicians would endanger patient safety. Yet we are the same resident physicians treating patients day in, day out in HRP member hospitals.

They assert that if I want volunteer on the weekend to work in a community mental health clinic I would create substantial administrative work to monitor compliance with current regulation and compromise our accreditation with the ACGME. So I'm a licensed doctor and if I want to take care of a patient without even accepting payment, I'm going jam up the administrative work of HRP and risk losing accreditation? Those are some pretty damning statements.

Administrative Work

First regarding substantial administrative work. According to HRP's 2007 990 disclosures, the CEO and General Counsel of HRP, earned over $170K in FY2007. Additionally 4 out of the 5 highest paid employees of HRP who are not officers, directors or trustees, required to be identified, are program administrators with salaries ranging from $57, 767 to $96,541. The top 4 highest paid employees are administrators. The last highest paid employee identified, is a resident physician who earns less than the CEO and less than any of these program administrators. It appears that we have substantive resources to help manage any minimal additional administrative effort. Further our programs currently monitor our duty hours meticulously. Bottom line regarding this point is it seems cruel that I should have to explain to a patient who'd like me to be their treating physician and whom I'd like to care for, that I can't treat them because it might create too much administrative paperwork.

ACGME Moonlighting & Accreditation

The last point in this testimony wherein they state these efforts, particularly with regard to duty hours, would "compromise our accreditation with the ACGME" is simply flat out wrong. As you are aware, the ACGME is the Accreditation Council for Graduate Medical Education and it is the body responsible for the accreditation for postgraduate medical training programs for medical doctors in the US. It is a nonprofit private council that evaluates and accredits medical residency and internship programs. The ACGME oversees the post-graduate education and training for all MD and the majority of osteopathic (DO) physicians in the US.

According to the May 20th, 2008 ACGME public written policy on Resident Duty Hours in the Learning and Working Environment the following is the Common Program Requirement:

F. Moonlighting
1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

The ACGME explains further,

Moonlighting: Consistent with ACGME Institutional Requirements (II.D.4.j), the written policy on moonlighting (defined as patient care activities external to the educational program in which residents engage at sites used by the educational program ("in-house" moonlighting) and other clinical sites, must include the following:

- residents must not be required to engage in moonlighting;
- a prospective, written statement of permission from the program director is required and must be maintained in the resident's file; residents' performance must be monitored for the effect of moonlighting activities and adverse effects may lead to withdrawal of permission.
- Program directors have primary responsibility for monitoring these effects.
- Internal (in-house) moonlighting must be considered part of the 80-hour weekly limit on duty hours.
- None of the other numeric standards (e.g., 10 hours rest period, one in seven free of all program responsibilities) apply.
- However the expectation is that the residents' total hours spent in-house will not exceed what is advisable for patient safety and resident learning and well-being.
- The intent is to apply the same standard to all hours residents spend in teaching institutions, whether those hours are part of the required educational program or are spent moonlighting in-house.
- In addition, it prevents institutions from inappropriately using in-house moonlighting to replace clinical service activities that residents may have covered previously as part of the educational program. Individual programs and institutions may prohibit or limit resident moonlighting and may wish to notify residents and applicants of any such restrictions.
- Additional questions related to this requirement are addressed in the duty hour FAQ: http://www.acgme.org/acWebsite/dutyHours/dh_faqs.pdf.

According to the relevant sections of the ACGME FAQs regarding moonlighting.

Duty Hour Limits and Resident Moonlighting and other Clinical Activities ***Question: Why does the ACGME distinguish between "in-house moonlighting," which is counted under the weekly duty hour limit, and external moonlighting, which is not included?***

Answer: The ACGME has two reasons for counting in-house moonlighting toward the weekly duty hours. First, this applies the same standard to all hours residents spend in teaching institutions, whether they are part of the required educational program or are spent moonlighting in-house. Second, it prevents institutions from inappropriately using in-house moonlighting to replace clinical service activities residents covered previously as part of the educational program.
The ACGME's purview extends to teaching programs and sponsoring institutions, but not resident activities outside of their educational program.

Question: Our residents engage in "in-house moonlighting." Which ACGME duty hour standards apply?
Answer: For internal moonlighting, the combined hours of residency education and internal moonlighting must comply with the 80-hour limit. None of the other numeric standards (e.g., 10 hours rest period, 1 in 7 free of all programs responsibilities) apply. However, the expectation is that the residents' total hours spent in-house will not exceed what is advisable from a patient safety and resident learning and well-being perspective.

Question: Some of our residents volunteer in a free clinic sponsored by our institution. It is not a required element of our program and residents do not receive pay for this activity. We are not sure whether this constitutes 'in-house moonlighting,' since the activity is voluntary and they are not being compensated.

Answer: Under the ACGME's definition, all clinical activities sponsored by the institution at which the resident trains are either part of the required educational program or 'in-house moonlighting.' If volunteer activities are done in lieu of other, regular program activities, they should be considered an elective. In that case, they are subject to all standards governing clinical activities that are part of the program.

If these volunteer activities are performed in addition to the hours in the program, they should be considered 'in-house moonlighting,' despite the fact that residents do not receive compensation.

So this is a pretty detailed explanation of what the ACGME thinks about moonlighting.

But this policy was dated May 20, 2008, so I contacted the ACGME and asked them if they had any new information regarding their stance on moonlighting, since complying with the ACGME standards is incredibly important.

This is what I wrote to the ACGME:

I'm currently a general psychiatry resident in Hawaii. Currently no residents in Hawaii are allowed to moonlight. Residents and faculty are currently exploring how we could put in place an effective moonlighting policy and ensure it is compliant with ACGME standards. The Duty Hours FAQ was incredibly helpful. As it was updated @ 2 yrs ago, I wanted to touch base with you and see if there was any additional information related to moonlighting that you'd recommend we consider. Additionally any guidance or resources you're able to offer regarding moonlighting for residents would be greatly appreciated.

I received this detailed response October 12, 2009 from Ingrid Philibert, PhD, MBA, Sr. Vice President, Field Activities and Managing Editor, JGME, ACGME, phone number 312/755-5003.

Dear Dr. Genen,

The FAQ is about to be updated, but the changes are minor, and none of the proposed revisions offer you new information about moonlighting. The general refinement in the ACGME's approach which also indirectly affects moonlighting is that we increasingly emphasize residents' personal responsibility for managing alertness for the patient care and learning process, as part of their contribution to patient safety and as a manifestation of their professionalism.

This approach recognizes that duty hour limits are pretty blunt tools, and cannot accommodate inter-individual differences. Moonlighting should be treated the same way. There are some residents and some specialties where the learning process leaves time and energy for added clinical work, and others where it does not.

Regards, Ingrid

So the ACGME has clearly defined rules for how programs should deal with moonlighting and I think it should be self evident that moonlighting in no way compromises a program's accreditation as has been asserted.

Precedence – Here and Other Residency Programs

Importantly I urge you to ask yourselves – is SB 2207 trying to do something that's never been done before? Does this bill propose something novel? The answer is a resounding no. Residents here in Hawaii used to be able to moonlight and volunteer. And the vast majority of our clinical faculty engaged in moonlighting when they themselves were residents. It's why many clinical faculty and the majority of the residents in our department signed a petition in favor of removing this restriction on moonlighting and volunteering activities. In fact one of your own colleagues engaged in moonlighting during his medical residency training.

Further the American Medical Association's publicly available FREIDA online database shows that >60% of psychiatry residency programs nationwide allow INTERNAL moonlighting which is within their own institution. On further investigation, the number of psychiatry residency programs that allow moonlighting outside their institution is even higher, as the database's core survey is specific to "internal moonlighting" (for instance Cedars Sinai does not allow internal moonlighting but does allow external moonlighting, but their program is shown as not allowing moonlighting within the database). Further **most importantly there is no program that prohibits their resident physicians from volunteering –** something HRP currently prevents its physician employees from doing. I confirmed this survey information with Sarah Brotherton, PhD Director of Data Acquisition Services for the American Medical Association, 515 N. State St. Chicago, IL 60654 P: (312) 464-4487 F: (312) 464-5830.

If top residency programs and hospitals like Yale and Cedars Sinai are able to effectively allow residents to moonlight and volunteer, why can't we?

If licensed physicians employed by HRP were not prohibited from moonlighting or volunteering, I believe there is a higher likelihood they would develop stronger roots in the community and would be more likely to make Hawaii their home at the completion of residency, caring for Hawaii's residents in need over the long-term.

One additional objection you may hear is that passage of SB2207 may increase the cost of malpractice insurance. Yet once again this is a fallacy. HRP provides malpractice insurance to its physician employees through a self-insurance fund and thus is not paying premiums. Importantly licensed physicians when they engage in moonlighting activities elsewhere typically have their own malpractice or it is provided to them by the employing facility.

As a licensed physician, engaged in a residency program here in Hawaii, I have one of the most rewarding and exciting jobs in the world. I want to take care of patients. But that ability is currently restricted. And it is wrong. Not only is it wrong, it is simply un-American. The taxpayers of Hawaii pay me, yet the nonprofit that administratively manages this money says I can only treat certain portions of Hawaii's population and they will decide which ones. But the state pays HRP over a $1.2 million a year.

What about Kauai, Maui, Molokai, the Big Island. What about Castle Medical. What about all the residents who rely on those facilities?

Do you realize that if a large natural disaster struck Hawaii, the large pool of licensed physicians employed by HRP would be contractually prohibited from providing care to patients except at the handful of hospitals in Oahu's HRP's member institutions? This situation is unconscionable.

Can you think of any profession where their employer forbids them from volunteering? Doesn't it seem crazy that licensed physicians paid by Hawaii's taxpayers can't even volunteer their services? SB 2207 provides simple redress to limited access to healthcare due to the physician shortage both in the immediate and long-term. I implore the members of this committee to do the right thing for all residents of Hawaii and pass this bill.

Thank you for the opportunity to comment on this bill.

PRESENTATION OF THE
HAWAII MEDICAL BOARD

TO THE SENATE COMMITTEE ON HEALTH

TWENTY-FIFTH LEGISLATURE
Regular Session of 2010

Wednesday, February 3, 2010
3:00 p.m.

TESTIMONY ON SENATE BILL NO. 2207, RELATING TO MEDICAL RESIDENCY.

TO THE HONORABLE DAVID Y. IGE, CHAIR,
AND MEMBERS OF THE COMMITTEE:

My name is Constance Cabral and I am the Executive Officer of the Hawaii Medical Board ("Board"). The Board has not had the opportunity to review this bill but will be discussing it at the next Board meeting on February 11, 2010. Therefore, it is not able to take a position at this time.

There is, however, a point of clarification necessary for this bill and that is, the bill should apply only to residents who hold a physician's license. The Board also issues limited and temporary "licenses" to medical residents who have not met all the licensing requirements. These licensees are not qualified to practice independently.

Thank you for the opportunity to provide testimony on S.B. No. 2207.

Wednesday, February 3, 2010, 3:00 p.m., Conference Room 016

To: Senate Committee on Health
Senator David Y. Ige, Chair
Senator Josh Green, M.D., Vice Chair

From: Hawaii Medical Association
Gary A. Okamoto, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Lauren Zirbel, Government Affairs
Dick Botti, Government Affairs

Re: SB2207 RELATING TO MEDICAL RESIDENCY - Comments

Chairs & Committee Members:

Hawaii Medical Association would like to provide comments on our concerns regarding SB2207 Relating to Medical Residency.

While we appreciate that this measure is intended to help cover gaps in physician coverage, HMA is concerned that the stringent resident workload combined with unsupervised "moonlight" hours could have a detrimental effect on resident training and patient care.

Thank you for your consideration and the opportunity to comment.

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Department of Health • Department of Veterans Affairs
University of Hawaii, John A. Burns School of Medicine

Written Testimony Presented Before the
House Committee on Higher Education, House on Health

February 3, 2010 at 3:00 p.m.

By

Richard Philpott, JD, LLM

Chief Executive Officer and General Counsel
Hawaii Residency Programs, Inc.

and

Designated Institutional Official
John A. Burns School of Medicine
University of Hawai'i

SB 2207 – RELATING TO MEDICAL RESIDENCY

Aloha, Chair Ige, Vice Chair Green and members of the Senate Committee on Health. Thank you for the opportunity to present this testimony. We genuinely appreciate this Committee's effort here to address the vexing problem of present and potential physician shortage on Oahu and the neighbor islands. While we do not believe this bill is the answer, we look forward to working with the legislature on an issue that affects all of the people of Hawaii.

I am the Chief Executive Officer of Hawaii Residency Programs, Inc. (HRP). HRP is the employer of all residents in Hawaii and the administrator of 15 nationally accredited residency and fellowship training programs.

In addition, I am the Designated Institutional Official (DIO) for the John A. Burns School of Medicine (JABSOM). This means that I am the senior representative from JABSOM to the Accreditation Council for Graduate Medical Education (ACGME). I am responsible for compliance with ACGME accreditation standards to ensure that our residency training programs continue to enjoy the excellent nation accreditation they have enjoyed for more than 20 years. The ACGME defines that DIO role as follows:

> *An organized administrative system, led by a Designated Institutional Official (DIO) in collaboration with a Graduate Medical Education Committee (GMEC), must oversee all ACGME-accredited programs of the Sponsoring Institution. The DIO and*

GMEC must have authority and responsibility for the oversight and administration of the Sponsoring Institution's programs and responsibility for assuring compliance with ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements.

In order to ensure that I perform my duties as DIO, I reply upon the expertise and knowledge of experienced "Program Directors" who head each program. They are appointed by the Dean of JABSOM and his predecessors, and are "on the front line" because they directly supervise both the supporting faculty and the residents. All have many years of experience training residents, and all have been in place for several years. I rely on them for advice as to what we must, and must not, do. Their responsibilities as Program Directors are defined by the ACGME requirements as follows: "*Program Director: The one physician designated with authority and accountability for the operation of the residency/fellowship program.*"

The DIO and Program Directors authority and accountability extends to both on-duty and off-duty activities and medical practice of residents and fellows.

Without the ability to exercise that authority and accountability as DIO and in turn as Program Directors – because that authority will be constrained by this bill - there will be no accredited residency training in Hawaii. This bill seriously endangers that accreditation – both for JABSOM as Sponsoring Institution and for all 15 component residency training programs.

I specifically join in Dean Jerris R. Hedges' testimony. I note in particular the importance – and success – of the JABSOM/HRP partnership, which for 27 years has produced more than half of the new board certified physicians entering practice in Hawaii. Without that steady flow of new doctors, Hawaii would face an unprecedented crisis.

We understand and appreciate the current physician shortage in Hawaii, both on Oahu, its rural areas, and on the neighbor islands. We are committed to continuing to do our part. In fact, the JABSOM/HRP partnership – which has trained 240 residents and fellows each year for more than 25 years – is singularly Hawaii's best and most reliable resource to address this problem. We've trained about half of the new physicians who have entered practice since we began our partnership. We simply must perpetuate that success. The people of Hawaii depend on it.

This proposed bill has the potential to jeopardize all that. If this bill passes, the ACGME will likely place JABSOM and all of its 15 accredited programs on probation – or worse. That is because this bill directly overrules ACGME accreditation requirements for DIO and Program Director responsibility, and seems to disregard national concerns for the protection of patient safety. I refer specifically to the National Institute of Medicine's recent report, "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety" (December 2008).

My joinder in Dean Hedges' testimony will specifically address the following 4 issues:

Why the ACGME will impose sanctions if the bill is passed

It is Program Directors who must monitor duty hours and the residents' practice of medicine outside the strict training environment (moonlighting). Because of ACGME requirements, and public safety concerns, this duty to monitor and control residents extends to off-duty practice and stress as well as on-duty practice and stress. As the ACGME and the National Institute of Medicine (IOM) have recognized, the extraordinary time demands and stressors of residency training make it unlike any other training position: Failure to supervise residents and monitor their stress have led to notorious cases of residents making mistakes while fatigued, resulting in harm to themselves and others.

The bill would limit the exercise of that required authority of Program Directors and accreditation officials.

Sometime in the next 6 months, the ACGME will conduct a 5 year site visit of the JABSOM/HRP Residency Training Institution and all of its component programs. At our last such visit in 2005, we received no citations and instead received two commendations, which are extremely rare. This will, however, be the first such visit under the new 2007 Institutional and Common Program Requirements, which contain enhanced Duty Hours and Moonlighting rules. I am convinced that this legislation will be an automatic citation, with the significant potential for probation or even withholding of accreditation.

There is no such thing as "practice within the scope of [residency training] in settings outside of [the training hospitals]"

Residency training is a structured experience which must meet very specific requirements in each specialty and each rotation. The ACGME provides more than 1500 pages of requirements for training generally, and typically 20-30 pages of fine print for each specialty. Every training experience outside of the central training hospital must be accompanied by a "Program Letter of Agreement" which contains goals and objectives corresponding to the particular requirement for that rotation, together with an agreed upon supervisor and formal evaluator. Typically all rotations are of at least 4 weeks duration. Hence there is no such thing as "practice within the scope of [residency training] in settings outside of [the training] hospitals."

Moreover, whether or not residents hold a permanent MD or DO license, accreditation requirements specify that they must practice under supervision. There is no such recognized supervision once the resident leaves structured training – and that creates extraordinary risk for the patients they might treat. Experienced faculty can manage that risk. Inexperienced supervisors, or unlicensed and inexperienced residents in training, can't.

Relaxing licensing standards will endanger patient safety

It is not clear which portion of Chapter 453 this bill is intended to amend, but relaxing permanent licensure standards to expand resident moonlighting is not in the best

interests of the public. No state in the nation extends unrestricted licenses to residents merely because they are residents. To do so would ignore the uniform national licensure requirement to pass the USMLE Steps 1-3, and be examined by a Board. Such licenses will not be recognized by the Federation of State Medical Boards. But worse, it will result in treatment for patients who reasonably expect that their physician has the credentials and competency they expect of all physicians – not someone who is still in training and meets only reduced standards to expedite care.

As a practical matter, this bill will not provide relief

Only 9 of our current residents currently hold permanent licenses which would allow them to practice outside residency. We can anticipate the argument that if residents were permitted to moonlight, more would obtain permanent licenses. Historically, that is simply incorrect: Between 1996 and 2006, before the onset of the new 2007 ACGME regulations, residents were permitted to moonlight but with strict qualifying requirements. During that time, the percentage of residents with permanent licenses did not vary substantially. And during that same 10 year period, only 20 residents in total (out of about 2,400) requested permission to moonlight. That's because they didn't have the time – even before the onset of the new duty hours rules. As both the ACGME and Institute of Medicine have recognized, the world of residency training has changed dramatically since that time.

Training medical school graduates to become board certified specialists demands skills, knowledge and expertise substantially beyond the ordinary practice of medicine. The 15 residency and fellowship program directors who manage our programs have more than 200 cumulative years of experience as residency faculty, and more than 45 years of cumulative experience as directors of ACGME accredited programs. It was their considered and unanimous decision, with the onset of the new ACGME regulations in July, 2007, that residents could no longer engage in moonlighting and still safely comply with duty hours requirements. And, of course, patient safety concerns figured prominently in their cumulative decision. We believe an unintended consequence of the bill would be to endanger the accreditation of the programs which they have managed so successfully.

Per the foregoing reasons, we respectfully request that the committee hold this bill.

From: don shaw [donshawaia@mac.com]
Sent: Wednesday, February 03, 2010 9:07 AM
To: HTHTestimony
Cc: Sen. Josh Green; Sen. David Ige
Subject: SB2207

To:
The Senate Committee on Health
Senator Ige, Chair
Senator Green, Vice Chair

From:
Don Shaw AIA

Re:
Support for Senate Bill 2207 ("Relating to Medical Residency")

Dear Senators Ige, Green, et.al.:

I am writing in support of this bill, as a lay person, because it will address some of the issues surrounding improving access to health care by disadvantaged and rural communities that have previously been brought before this committee, in a prudent and reasonable manner.

As you know, the lack of access to physicians by some parts of our state's population has been used to justify a variety of proposals.

Some of these proposals have involved asking the state legislature to circumvent both basic scientific and professional education and training, so that non-physicians can be substituted for physicians, under certain conditions.

I have opposed these efforts because I feel, (as a former UH professor and as a practicing professional), that these proposals may establish a dangerous precedent in allowing legislation to pre-empt the universities prerequisites for professional education.

Senate Bill 2207 addresses the issue of access to physician's services directly: by removing artificial and unnecessary limits on the activities of medical residents, thereby increasing the number of physicians available to the public, without undercutting professional education or standards.

Thank you for your consideration in this important matter.

Regards,

Don Shaw AIA

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