
Public Hearing

before

ASSEMBLY REGULATED PROFESSIONS AND INDEPENDENT AUTHORITIES COMMITTEE

ASSEMBLY BILL No. 1852

(Establishes limits on medical resident's hours)

LOCATION: University of Medicine and
Dentistry of New Jersey
Newark, New Jersey

DATE: May 7, 2002
12:00 p.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Anthony Impreveduto, Chairman
Assemblyman Matt Ahearn



ALSO PRESENT:

Laurence A. Gurman
*Office of Legislative Services
Committee Aide*

John Fuller
*Assembly Majority
Committee Aide*

Eileen M. Mannion
*Assembly Republican
Committee Aide*

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ASSEMBLYMAN ANTHONY IMPREVEDUTO (Chairman):

Good afternoon ladies and gentleman.

And let me thank you, Eric, Dr. Eric Munoz, for inviting us here to the New Jersey University of Medicine and Dentistry for this hearing on a very, very important issue, the issue of the hours that medical residents should be working here in the State of New Jersey.

But before we go further into that, let me introduce all who are up here at the dais. To my left is Assemblyman -- we're going to put his Assemblyman hat now on and take off his University of Medicine and Dentistry --

ASSEMBLYMAN ERIC MUNOZ: White coat off too?

ASSEMBLYMAN IMPREVEDUTO: White coat.

And introduce him as Dr. Assemblyman Eric Munoz, who is the co-prime sponsor of this particular legislation. And many of the folks in here wearing white coats or stethoscopes around their neck will also know who this gentleman is to my left. A good friend, a good legislator, and, certainly, one heck of a doctor.

To my far right, well, second from the right, is Assemblyman Matt Ahearn. Matt is a cosponsor of this piece of legislation and a member of this Committee.

To his right is John Fuller, a Democratic Legislative Aide to the Committee.

To my immediate right is Larry Gurman. Larry is with the Office of Legislative Services and wrote this particular piece of legislation because I don't speak good enough English to write it.

And, certainly, Eric will introduce the young lady to his left.

ASSEMBLYMAN MUNOZ: Thank you, Tony.

This is Eileen Mannion, who's from the legislative staff in Trenton.

And if I can just say a couple of words, because I think that remembering that you're in an academic institution, you're here at the UMDNJ New Jersey Medical School -- and, I think it's important for many of the doctors-in-training to realize that, you know, we have a whole system in the way medicine is taught and the way we become physicians. We have the same thing in Trenton.

Chairman Impreveduto heads a committee of the State Assembly which creates bills, debates bills, and then, after those bills come out of committee, they go to the Assembly floor. They're voted on, yes or no, and after a bill passes the Assembly, it then goes to the Senate, passes the Senate, and then signed into law by the Governor. So, I think that a number of you got an E-mail that said -- actually, you're seeing a health policy in action, and this is exactly what's happening here.

So, I think, with that, I'm going to turn back to Assemblyman Impreveduto because, you know, this is the kind of thing that we now do -- what happens in Trenton. Really, there are very, very many smart people and worthy people in Trenton that are out to help you. And so--

Mr. Chairman.

ASSEMBLYMAN IMPREVEDUTO: Well, we have taken Trenton to here, and that's why we're here. We're here today to hear Assembly Bill No. 1852, and it was introduced on February 21 by myself, as the co-prime sponsor; Eric Munoz as the second co-prime sponsor; and the third co-prime sponsor, Matt Ahearn, again, to my right.

So, what we do -- and let me give you the ground rules. We have sign-up sheets. If anyone wishes to speak, please see Larry and he has a small piece of paper for you and please sign that. Tell us who you are, where you're from, whether you are speaking for or opposed to the particular piece of legislation, or if you're not opposed or for it, but you just want to have a statement read, we ask you please to do that.

I ask that when you come up to speak that if you have prepared testimony, that you do not read your prepared testimony. Certainly, it's important. We do have some time constraints. We ask that you summarize your written testimony. If you have made enough copies, please hand them out to us, and we can read that as we go. But I ask you again, please do not read your prepared testimony. Give us a summary and, also, we would certainly request that -- there are going to be some questions asked of you, as you come up, from some member of the panel here. So, please bear with us if we ask you some questions and request some answers.

We're here to fact find. It's important for us to know what your feelings are about this legislation. It's good, it's bad, it's indifferent. Whatever it may be, we need to know that in order to prepare a bill that is the best bill for the residents and for the people of the State of New Jersey.

So, after that is said, Larry, do we have a list of witnesses?

MR. GURMAN (Committee Aide): We do have a witness list.

ASSEMBLYMAN IMPREVEDUTO: Our first witness we'd like to ask you to testify, is a doctor, Dr. Bell, from Albert Einstein College of Medicine.

Dr. Bell.

B E R T R A N D B E L L, M.D.: (speaking from audience) Here?
(referring to podium in front of panel)

ASSEMBLYMAN IMPREVEDUTO: Absolutely.

And thank you.

ASSEMBLYMAN MUNOZ: Actually, if I may jump in, Mr. Chairman, to introduce the speaker?

Dr. Bell's name is associated with a lot of the legislation that has been, you know, throughout the United States, especially New York.

Dr. Bell, welcome.

DR. BELL: I thank you very much.

I really don't need any notes since I'm the world's expert on this particular topic.

I looked over the legislation. It looks pretty good. You see, I won't be crazy about this, but one of the things I'd like to emphasize, and I can take any questions, is that in addition to the madness of allowing young doctors-in-training to be scheduled sleep deprived, to be allowed to be chronically fatigued, they also are poorly supervised, at least they were in New York State. So I would strongly emphasize that in the legislation you include the idea that there's always available, on the spot, a collegial supervisor, like me -- I'm a PGY-46 -- who's around to ask when you don't know.

ASSEMBLYMAN IMPREVEDUTO: Could you please -- PGY-46 is about my waist size about now, but I'm not sure what that means.

DR. BELL: Well, my waist size used to be 46.

Interns are referred to as PGY-1s, post-graduate year one, two, three, four. And I've been around for 46 years in medicine. I'm not going to

tell you when I went to medical school, but as a post-graduate trainee, and so that -- I mean, that's all I really need to say.

If you have any questions about what's going on in New York State and how we've succeeded and what's going on around the country, I'd be more than glad to do that for you.

ASSEMBLYMAN IMPREVEDUTO: Well, if that -- you've read our bill. You know that we pretty much mirrored the New York State law.

DR. BELL: Except you left out the supervision pieces of it.

ASSEMBLYMAN IMPREVEDUTO: And if I'm -- Laurence, you're fired. (laughter)

If we did leave that out then, and I do agree with you, and then, certainly, we'll speak to Eric about that, but right -- I probably do agree with you that that's an important piece.

We'll let -- Eric, I'm sorry. Go ahead.

ASSEMBLYMAN MUNOZ: Yes.

Let me just ask Dr. Bell a question. And I think that you make some good points. There's an entire system in the United States that actually monitors residencies. For example, I'm a surgeon and there are worthy committees that, you know, overview the residency training and part of that training is to ensure -- back to Dr. Bell -- that residents are supervised. Meaning, many, many years ago, you could actually have situations where doctors-in-training really weren't properly supervised. I think in the last decade to two decades, really, we've addressed that quite well.

Back to Dr. Bell, do you think we need a law that should say that?

DR. BELL: Here's what I think. I think that -- I've listened to how well Arthur Andersen was supervised. So that, I happen to, you know, be

one of these people who really believes that if you put something into law, people then will get the message. You know, there are a lot of laws that people don't follow. I'm not going to go into which ones they are, but there are some laws that people don't follow.

I think that what's happened in New York State, as a fact, is that something that used to be referred to as ghost surgery is gone. And I think that we've played a role in that by -- and it was something that -- you know, surgeons are artists. They respect their craft. And this -- I mean, I'll make a flat statement. The people in the state of New York who supervise the law have made it clear that what you say is true. That does not mean that it shouldn't be in the law that this is the right thing to do, because there are plenty of circumstances where that doesn't happen.

Like, for example, at Mount Sinai recently, where somebody died for totally unnecessary reasons because you asked an intern to be running a service like that. Thirty-four post-op liver transplant patients with one intern and no supervisor. Sorry. You need a new law.

ASSEMBLYMAN MUNOZ: And I want to further comment, you know, and I agree with some of what you're saying. For 10 years, I was the Chief Doctor of this hospital, and for 4 years I was the Director of the Residencies. It means we have 700 medical doctors-in-training. And the question is, and if you look at the Mount Sinai recent issue, is no one wants that to ever happen. I mean, trust me. There's no one in the hospital--

DR. BELL: I know that. Please, I'm a doctor.

ASSEMBLYMAN MUNOZ: --but it happens. And the question becomes, you know, I'm now a State legislator and can my passing a law help prevent that? That's where--

DR. BELL: I think that if you pass a law, and you make it that if someone breaks that law, that they go to jail or you put something behind it, people try to adhere to the law. I mean, I've even seen people in New York no longer using their cell phones. They have to have little things in their ear. So, you know, I think that what you do with certain kinds of laws which deal with human behavior is you set a standard.

My oldest daughter, who happened to have been in Jersey recently in regard to the anthrax investigation -- she's with the CDC. When I was involved with this, she's the one that said to me, "You know, Daddy, you can't legislate responsibility, but what you can do is set a standard." And that's what you want to do.

ASSEMBLYMAN IMPREVEDUTO: Just for the benefit of those who are here that may not know all of the intricacies of this piece of legislation, Larry, would you please just give us a brief rundown about what this bill does. But before you do that, I want to take the prerogative of the Chair, and, Doc, I'm going to ask you just to remain right there because I've got something that I need to ask you.

I take the prerogative of the Chair and introduce someone whom I'm very proud of, my nephew, Michael Miller, who's standing right back there, who's graduating in May. So, Michael's here to listen to what good things we can do. And he's, in fact -- matter of fact, going over to your place.

DR. BELL: He's coming to Jacobi?

ASSEMBLYMAN IMPREVEDUTO: Beth Israel.

DR. BELL: Oh, that's downtown. I push the Bronx to everybody. Come to Jacobi. It's great. I'm there. (laughter)

ASSEMBLYMAN IMPREVEDUTO: But -- now after I've taken that prerogative, Larry.

MR. GURMAN: A-1852 regards general hospitals that employ medical residents to establish the following limits on working hours for the medical residents who have inpatient care responsibilities: one, the scheduled work week for a medical resident shall not exceed an average of 80 hours per week over a four-week period; two, on-call duty during night shift hours for a medical resident shall not be scheduled more often than every third night; three, a medical resident shall not be scheduled for more than 24 consecutive hours in either patient care or educational sessions; four, a medical resident shall have at least one 24-hour period of scheduled nonworking time per week; and five, a medical resident shall not be scheduled for more than 12 consecutive hours of patient care in an emergency department.

A hospital that's in violation of these staffing requirements would be subject to the penalties described in the Health Care Facilities Planning Act, which include a civil penalty of not more than \$2500 for each day the facility is in violation.

ASSEMBLYMAN MUNOZ: Just to add on one -- to not be confused-- In the field of clinical medicine, there are psychiatrists, there are obstetricians, and many of us, when you talk about medical resident -- if you say it in the hospital, that would mean doctors that are in the field of medicine, not surgeons. But really that terminology means any physician in training. We might need a language change, but, for example, the New Jersey Medical School has 700 doctors-in-training in 50 different areas, but that's what we mean by medical residents -- meant by a doctor-in-training.

DR. BELL: I think in the New York State law, it just refers to residents--

ASSEMBLYMAN MUNOZ: Right.

DR. BELL: --with the idea that people-- I was going to make the same--

ASSEMBLYMAN MUNOZ: Correct.

DR. BELL: --addition to--

ASSEMBLYMAN IMPREVEDUTO: Dr. Bell, we hear, and I've certainly heard folks say that, "Hey, a doctor's hours are a doctor's hours." And things happen when you least expect them to happen. And that might be 1:00 in the morning or 7:00 at night or midnight. Why shouldn't they be there at the hospital? I mean, that's their job. They're going to learn better working with patients. The textbook stuff is over. Now it's time to work with people and other physicians in the training of medical doctors. Agree? Disagree? Why?

DR. BELL: Well, first of all, young doctors are human beings, and everybody needs a certain amount of sleep. And as someone who has been teaching people for a very long time -- I have other titles as well as this one -- people can't learn if they have been up for inordinate and nutty hours. I mean, stuff that does not allow people -- you're not healthy. So, you can't learn if you're not healthy. That's one very, very important reason.

The other reason is that when you're learning you're at the bottom of the scale, and you're learning about responsibility, and this is not a single kind of a thing. So that it is sort of, really, a bad way of dealing with things to make the youngest person, the person you're going to wake up at 1:00 in the

morning, if it's really a difficult kind of thing, and if you're going to do that, the person has to be awakened.

You know, times have really changed. You might hear old men like me talking about, "Well, we did it, right?" But when we did it, first of all, there was a doctor's dining room. We had a staff house where we slept. The nurses respected us in a wonderful kind of way, they called us doctor. They wouldn't wake us up once we went to bed.

In fact, you know, what's interesting is that, in those days, we didn't have all the stuff they have now. So, if someone died in the middle of the night -- people are allowed to die -- they would call you at 6:00 in the morning to come and pronounce the patient. If I talked to these kids here about pronouncing a patient, they're not going to know what I'm talking about. They would wake us up early in the morning, like 6:00 or 7:00, to come over there to say this person is dead. So, the times have changed.

And, I mean, it just doesn't make good sense to ask a pilot to fly an aircraft after he's been up for 24 hours.

ASSEMBLYMAN IMPREVEDUTO: Does anybody have a -- jump right in.

ASSEMBLYMAN MUNOZ: Through the Chair -- seems the way we do things -- here's a question then. Some of my colleagues say, "You know, look, being a surgeon or a neurosurgeon," take for example, "means being up at 2:00 or 3:00 in the morning and operating on people." And isn't it appropriate that while you learn to be a neurosurgeon, not that you should learn to be tired, but that, you know, the actual practice of neurosurgery means that sometimes in the middle of night you might be tired, working on people. Isn't the best experience to train under more realistic conditions? I mean, I

know -- I'm not trying to stretch it. It's almost like how you train people for battle and, like, not have bullets involved, but, you know, it's an argument that maybe that's part of the training.

DR. BELL: The neurosurgeons that I know who get up to operate at 2:00 and 3:00 in the morning, where a big trauma plays, haven't been up for 24 hours. Now I'll grant you, they may have left the hospital at 7:00 or 8:00. They may not be exactly up, but having them doing this all week and so on.

The big issue here has to be with learning the big *R*, which is responsibility. Now, if I am responsible for somebody and they need me, damn it, I am going to go and see them. That's responsibility. That's part of the training program. And if I have to be there, I know that I have to be there, I will be there. But that is what the issue is, not what you're talking about. I mean, I am there when they need me.

And you know, the kids that I supervise will call me in the middle of the night, and they know if they don't call me on something that they're not certain about, and they want to hear what this old man has to say, I will kill them in the morning. It's as simple as that. It's responsibility, and it's collegial.

ASSEMBLYMAN IMPREVEDUTO: How does it work in New York?

DR. BELL: Well, for a while -- you know, my daughter said you can't legislate human behavior. It didn't work. And then Governor Pataki's people finally went ahead and -- *The New York Times* is very helpful. And on the front page of *The New York Times* in 1998 was a review of statewide residency programs, that found that people weren't complying -- in particular, surgeons. Something like 72 percent of programs. And they increased the

amount of money that hospitals had to pay. And I can assure you, hospitals don't like to be on the front page of *The New York Times*. And so, since 1998, if you speak with the people in the state health department -- it might be useful to do that -- people are more rather than less compliant. And the message is getting across to people.

ASSEMBLYMAN IMPREVEDUTO: But it seems to have taken a different turn. It seems to be a better program than --

DR. BELL: I think that in New York State those regulations are working. And if you talk to kids who speak with -- you know, join our residency programs, kids like it. You know, you have time to go to the bathroom if you're a resident. That's useful. (laughter from audience)

ASSEMBLYMAN MUNOZ: You know, it actually just popped into my head. If the program in New York has been -- and we could argue about what the word effective means -- I guess, we were just talking about Mount Sinai a few weeks ago -- it was in the news, it doesn't seem like the law has had a great impact, at least, preventing everything.

DR. BELL: I think it's very sad actually because, you know, the program at Mount Sinai happened to be a very good program. But I can assure you that program is going to be revamped. The program at Presbyterian is being revamped. I mean, you know, the message is there, and it's sad that people have to die because of this. Keep in mind, the whole thing started out with the Libby Zion thing.

ASSEMBLYMAN MUNOZ: Yes.

DR. BELL: So that it has to do with the word responsibility.

ASSEMBLYMAN MUNOZ: Dr. Bell, why don't you, for some of the younger people in the room, tell what the Libby Zion thing is because that

was, I think, about 10 years ago, and some of the folks were a touch younger than we were.

DR. BELL: Actually, it's a very sad story. Libby Zion actually died in 1984, which -- he must be getting old because that's more than ten years ago. I'd say you're getting old. So, I don't know.

And Libby Zion was 18 and her father, Sidney Zion, happens to be a famous journalist. And you have to keep in mind that you never want to know about the idea of losing a child. She went into the hospital with what they thought was an earache. She was never ever seen by the attending doctor. The people who took care of her was an intern, and a PGY-2 took care of her. And she died, probably, because of an inappropriate use of meperidine, Demerol. And she died from -- I'm blocked for a second -- a malignant high fever syndrome.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Malignant hyperthermia.

DR. BELL: It's not malignant hyperthermia. It has got some other name. And that's what she died from.

And I'm sorry. Who's got it?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Malignant neuroleptic.

DR. BELL: Malignant neuroleptic, there you go. That's what it is. And that's what she died from. And her father -- I mean, you don't -- it was a child. And so he took the story to the district attorney, and the district attorney put together a grand jury which wanted to indict the doctors for murder, and instead they indicted Graduate Medical Education. We had a

great Democratic Governor by the name of Mario Cuomo, who was smart enough to appoint me to look into this, and there it is. It's all history.

ASSEMBLYMAN IMPREVEDUTO: Dr. Bell, I'm going to ask if you would, if you have the time, and would consider being around for a little bit--

DR. BELL: I'll hang around, provided they get me back to work later this afternoon.

ASSEMBLYMAN IMPREVEDUTO: And we'll talk -- and in case there are some questions, I'd like to have you--

DR. BELL: Okay. Fine. Please.

ASSEMBLYMAN IMPREVEDUTO: Our pleasure.

DR. BELL: Good luck, everybody.

ASSEMBLYMAN IMPREVEDUTO: Our next witness, if you want to call him a witness, certainly is someone who's extremely important to all of you and to all of us who live here in New Jersey and work here in New Jersey and go to school here in New Jersey -- Dr. Stuart Cook, who is President of UMDNJ.

Dr. Cook, thank you for being with us.

STUART COOK, M.D.: My pleasure.

Good afternoon, Chairperson Impreveduto, Assemblyman Munoz, and Assemblyman Ahearn, and members of the Committee.

I'm Stuart Cook, President of UMDNJ. Allow me to welcome you to our newer campus and to the New Jersey Medical School. This is a busy time at our University as our students are finishing their semesters with final exams, and our fourth-year medical students are preparing for graduation to

move on to the next phase of their professional development, residency training in their chosen specialty area.

And of course, you are here today to begin what I hope will be a comprehensive and ongoing dialogue about graduate medical education in our State, specifically, Assembly Bill No. 1852, cosponsored by Chairperson Impreveduto and also by a distinguished member of our faculty here at New Jersey Medical School, an individual of whom we are very proud, Professor and Assemblyman Eric Munoz.

My role today is a simple one, to welcome you to our State's University of the Health Sciences and to pledge our cooperation and support to the Committee as it undertakes the challenge of addressing some of the important issues surrounding how we are preparing the next generation of physicians in New Jersey.

The matter of when and for how long interns and residents train has been debated for many years, even when I served at my residency in New York City in neurology at Albert Einstein College of Medicine. And I won't tell you when that was -- many years ago.

I applaud the sponsors and the Committee for tackling this issue at this particular time. It's certainly a very important issue for all of us who practice medicine in the State of New Jersey. Your hearings will do much to enlighten all of the interested parties as to the complex nature of medical education.

In today's world of technology and cost containment, it is especially important that the public, all consumers of health care, understand the many pressures bearing on physicians and hospitals in this environment and understand that our number one concern is always to ensure the safety

and confidence in our health-care delivery system. We need to make sure that our whole staff are well-educated and, most importantly, that our consumers are protected and assured of the best possible health care.

We at UMDNJ will, along with the members of the Committee, listen carefully to the information brought before you. We urge you to seek to go beyond the anecdotes, as compelling as they will be, to reach the real problem areas, validating them through solid data and then defining your final recommendations. Perhaps you will even find that existing voluntary rules governing residents-in-training, developed and monitored by the various professional academies and residence review commissions and other accrediting bodies, are working hard and that legislation may not be warranted.

Whatever your conclusions, be assured that the full resources of our University are here to assist you in your mission.

Thank you very much for allowing me to address you today.

ASSEMBLYMAN IMPREVEDUTO: Stuart, thank you very much for taking the time to be with us.

DR. COOK: Thank you.

ASSEMBLYMAN IMPREVEDUTO: Okay.

I'm going to ask Ms. Jean Pierce, from the Patients First Coalition, to testify.

J E A N P I E R C E: Good afternoon, Assemblyman Impreveduto, Assemblyman Munoz, panel. Thank you so much for hearing me today on the topic of quality of patient care and resident's hours.

I'm here on behalf of the Patients First Coalition. We are a coalition of care givers, patient's advocates, labor organizations, and community groups. With our principle members, 1199J, HPAE, District 1115,

SEIU, and CWA, we represent 40,000 health-care workers in New Jersey. We do not represent physicians, but we represent the professionals that support their work and the patients that they care for.

The Patients First Coalition has been at the forefront of the push for legislation that will improve the quality of patient care while protecting the health care of the workers of our State. Over the past several years, we have seen the quality of patient care deteriorate. With downsizing and managed care, hospital staff is to the bare minimum.

A Lewis Harris Poll indicated that more than two out of five U.S. adults said they had first-hand or second-hand knowledge of medical errors. When asked to identify the main cause of the mistake, over a quarter of the respondents said it was because of situations where the health-care professional was fatigued, overworked, stressed, and hurried.

Studies have shown that when a worker exceeds 12 hours of work and is fatigued, the likelihood of errors increase. Presently, physicians in New Jersey work 90 to 120 hours per week on shifts as long as 36 hours. These hours present dangers to the patients they care for, the public at large, as well as to themselves. After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent of having a 0.1 percent blood alcohol level. In this state, you would not be able to drive, but a doctor can take care of a patient for more than 12 hours past that time.

The Institute of Medicine has cited 98,000 deaths in one year over medical errors. Their report recommended addressing the issues of work hours, workloads, and sufficient staffing to avoid the errors from occurring. Errors made by exhausted professionals in the field can seriously harm patients and, at worst, can be deadly.

Patients in hospitals are more acutely ill and are discharged more quickly. At a time when patients need more care, they are getting less, and often from tired and stressed care givers.

The Patients First Coalition fully supports Assembly Bill No. 1852, common sense legislation that will help create safe working conditions for our health-care providers as well as for the patients that they're caring for.

Thank you so much for your time.

ASSEMBLYMAN IMPREVEDUTO: Does anyone on the panel have questions for--

ASSEMBLYMAN MUNOZ: You know, just to comment, I don't disagree with what you're saying. For the record though, the medical schools in New Jersey have done audits after the New York law was passed, and a lot of states started to look at voluntary guidelines, you know, of 80 hours. The medical schools in New Jersey did audits, and this medical school was the largest. The New Jersey Medical School found basic compliance. I mean, I don't want the audience to think that all the doctors-in-training are working 100 hours or 110 hours a week. There are some areas though that could be problems, but most of the doctors-in-training, you know, work under 80, but that might not be all the doctors-in-training.

MS. PIERCE: Thank you very much for your time.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

Mr. Rob Levy, American Medical Student Association.

ROBERT S. LEVY: I want to thank the Chairman for inviting me to attend today's hearing. My name is Robert Levy. I work as the Legislative Affairs Director for the American Medical Student Association. The American Medical Student Association is the nation's largest independent medical

student association. We represent over 30,000 medical students across the nation.

First question to answer is, why is the American Medical Student Association involved with this issue since we represent mostly medical students and not residents? The answer is really quite simple: we have the time and residents don't. (laughter)

The American Medical Student Association, or AMSA as we call ourselves, have been working on this issue for approximately the last two years. I remain the only individual in this nation of 300 million people who's paid full-time to work on this issue, and I have been doing so for the last 12 months. AMSA has wide breadth of experience with this issue. We've done a number of things over the last couple of years; namely, we lead the coalition that helped introduce and helped support federal legislation, HR 3236 in the United States Congress, that also calls for limits of 80 hours per week, 24 hours per shift, etc., etc.

That bill now has the support of 60 members in the United States Congress including a number of members of the New Jersey Congressional delegation. In addition, AMSA cosigned a petition to the Occupational Safety and Health Administration on April 30, 2001 that also calls for limits of 80 hours per week and 24 hours per shift.

We have compiled a compendium of work hour stories from residents across the nation. We've led the effort to make this a public issue. We've also led a grassroots effort that has resulted in over 11,000 E-mails, letters, and phone calls to various members of Congress from medical students, residents, and patients from around the nation.

So, again, why do we get involved? To put it simply, a combination of factors, including particular aspects of the culture of medicine, lax rules, and poor enforcement, have led to the only solution, the only viable solution to this issue at this point, which is legislation, whether it be Federal or State.

The effects on residents and patients are quite clear, as I'm sure you are well aware. Long work hours lead to high rates of car accidents among residents, high rates of depression among residents, and high rates of pregnancy complications, not to mention medical errors and poor attitudes towards patient care.

Indeed, if you'll indulge me for just a minute, I'd like to read one story from an orthopedic surgery resident from northern California.

"I was operating post-call after being up for over 36 hours and was holding retractors. I literally fell asleep standing up and nearly face-planted into the wound. My upper arm hit the side of the gurney, and I caught myself before I fell to the floor. I nearly put my face in the open wound, which would have contaminated the entire field and could have resulted in an infection for the patient."

On our Web site, www.amsa.org, we have a link through which residents and former residents can submit stories concerning their experiences during residency. A former resident in Massachusetts General Hospital, which is Harvard University's hospital, wrote in, "Like the ortho resident, I fell asleep during surgery. In this case, however, I was holding a heart during a bypass."

We've had other stories as well. Another resident wrote, "After a 36-hour shift, the drive home seemed surreal, and I'm surprised I haven't yet been in an accident. Once more, 36 hours without sleep, and they're letting

me see patients, they're letting me operate. I once accidentally made a bowel serosa opening for a hysterectomy. I thank God the injury wasn't worse and that the patient did well afterwards."

The stories can go on and on and I have dozens more; however, we do have time limits here that I will respect.

So, to get down to the heart of the matter, what are the current rules for residency work hours? Seeing as how New York is the only state in the union that has state legislation, the rest of the nation is governed by the ACGME, which is the Accreditation Council for Graduate Medical Education. The ACGME allows individual residency review committees to develop rules for their own individual specialities. Some of them are particularly galling.

For instance, in general surgery, the rules themselves, right off of the ACGME's Web site, I quote, "Patients have a right to expect a healthy, alert, responsible, and responsive physician." This is for general surgery, and yet, they have no hour limits whatsoever.

Once more, they go on to say, and I quote, "It is desirable that residents have at least one day out of seven free and be on-call no more frequently than every third night." Note the word desirable. They don't even think it's reasonable to have a resident have one in seven days off. They simply ask that each of the program directors around the nation try, if they can, to abide by the rule that a resident should have one in seven days off.

So, what have these rules led us to? How many hours do residents actually work? Well perhaps the most comprehensive data has yet to be published. In fact, it has been submitted for publication, has been presented publicly by a well-respected member of the medical community. The data that he presented showed that pediatric residents across the nation -- and I might

add that this is a survey of over 4000 first- and second-year residents -- pediatric residents work, on average, 80 hours per week; OB/GYN residents work, on average, 91 hours per week; general surgery, 104 hours per week.

It's probably good for me to go back to the current rules now. General surgery working 104 hours, on average, per week and yet the rules that they're supposed to be following state that patients have a right to expect a healthy, alert, responsible, and responsive physician.

I won't tell you what or how to think, but I will state this question. If a surgeon is working 104 hours, do you really think they're healthy, alert, responsible, and responsive to the patients that they need to attend to? It's unlikely. The hours that they work wouldn't be such a problem if the hours that they worked included sleeping time during the time that they were in hospitals. However, that's not the case either.

A study published by the OB/GYN profession back in June of 2001 showed that 60 percent of residents, first -- excuse me, 60 percent of OB/GYN residents all across the nation -- again, survey of 4500 residents this time around -- 60 percent of all of the OB/GYN residents across the country surveyed said that they want their hours restricted out of a fear that the hours they're working are compromising the quality of care they give.

So, why turn to the government, which is really why we're all here today? Why not allow the medical community to regulate themselves? Why not allow them to police themselves? Why can't they fix this situation on their own? It's really quite simple. They can, and they've chosen not to.

So, why do we turn to the government? First, Assembly Bill No. 1852 places reasonable limits on work hours, work hours that are supported by medical students, resident physicians, and attending physicians across the

nation. Indeed, even the American Association of American Medical Colleges, which represents this institution, supports work hour limits of 80 hours per week and 24 hours per shift. However, that leads to the second reason why we need to turn to you, the government, to fix this situation.

The AAMC released their proposal last October, October of 2001. They said we now support 80 hours per week and 24 hours per shift. What they didn't tell everybody was that they supported 80 hours per week since 1988. In fact, that was listed in the *Journal of Medical Education* in May, 1988. So, for the next 13 years they did absolutely nothing to advocate for an 80-hour limit. Clearly, they were putting on a show. This is why the government needs to get involved.

And finally, the government needs to get involved because enforcement by the medical community simply doesn't work. As it currently stands, there is no anonymous reporting system for residents to report complaints about their particular program. Clearly, many residents are reluctant to go to their program directors, who write their letters of recommendation at the end of their residency.

They could go to the ACGME, but the ACGME does not offer a method by which they can remain anonymous. The ACGME will tell them, "We'll keep your name confidential," but that's a heck of a risk for residents to take.

ASSEMBLYMAN IMPREVEDUTO: Rob, can I just interrupt you for a second. Now ACEME (*sic*) and ACGME and all the alphabet soup makes a lot of sense to the folks wearing white coats and stethoscopes here, but to us lay folks it doesn't mean a whole lot. So we need you to tell us what that means.

MR. LEVY: Okay. Sure.

Again, the ACGME is the Accreditation Council for Graduate Medical Education. They are the authority on resident work hours as it now stands. Their residency review committees make the rules for residency training throughout the nation. The only exception is New York State, which has state legislation regulating work hours. So, in every state, including New Jersey, besides New York, the ACGME develops the rules by which residents or residency programs must guide their own residence. In certain specialties there are limits and in others there aren't, such as surgery and OB/GYN.

The problem comes down to whether or not the ACGME, the Accreditation Council for Graduate Medical Education, is really in a position to police themselves. I've already stated that they provide no method of anonymous reporting for residents. In addition, they have no objective system by which to measure compliance with whatever work hour rules do exist right now.

But most importantly -- and this is where I would like to direct your attention for the rest of the time I have up here -- we get to the issue of public disclosure. The ACGME currently cites a number of hospitals throughout the country for work hour violations. However, they won't release the method by which they do that, and they won't tell us which hospitals-- They won't tell us the reasons why the hospitals are cited.

So, for instance, one of AMSA's recent successes is in exposing Yale's surgical residency program's failures. Yale has lost its accreditation. This is an Ivy League institution. They've lost their accreditation from the ACGME because they work their surgical residents too hard. Now, if you were to call the ACGME and ask them, why did you pull Yale's accreditation, they

will refuse to tell you. They will not disclose publicly the reasons why any hospital across the nation loses its accreditation. That needs to change.

As Dr. Bell said, the Bell regulations in New York were not enforced until *The New York Times* publicly disclosed the problems with enforcement back in 1998. Public disclosure is what works, and it's what the American Medical Student Association would urge you to follow for a means of enforcement with Assembly Bill No. 1852.

In addition, I would like to point out a document I have handed to both Assemblymen. I have to apologize, Mr. Ahearn, I did not expect you to be here.

ASSEMBLYMAN AHEARN: It's okay.

MR. LEVY: It's an internal document that we received concerning the Accreditation Council for Graduate Medical Education's worries about federal intervention on the resident work hour effort.

I quote from that letter -- I have additional copies if other people would like to see it as well -- "The ACGME may call upon the residency review committees to revise again their criterion for work hours to meet mounting federal pressure." This letter was sent out over the summer shortly after our OSHA petition was filed.

The OSHA petition was the first time any group of individuals went to the federal government and said, "You guys need to get involved with this issue. The medical community has had decades to deal with this and they haven't." The OSHA petition, as one colorectal surgeon at Washington University told me in September, "was like a terrorist attack on the medical community."

That's the fear that legislation strikes in the hearts of the medical community, and that's why you need to push ahead with your Assembly Bill No. 1852. Legislative pressure is the only impenetrable force which can move the seemingly immovable object we call graduate medical education. Again, far from rhetoric, I point you again to the ACGME's internal document that seems to corroborate that statement.

A couple of other comments I'd like to make concerning another Assembly bill in New Jersey --

ASSEMBLYMAN IMPREVEDUTO: Before you do that--

MR. LEVY: Sure.

ASSEMBLYMAN IMPREVEDUTO: --and let's get your testimony to this bill.

MR. LEVY: Sure.

ASSEMBLYMAN IMPREVEDUTO: Okay.

Assemblyman Ahearn has a question.

MR. LEVY: Sure.

ASSEMBLYMAN AHEARN: You mentioned that Yale lost its accreditation from the ACGME. As a practical matter, what does that mean for the school? Do they still get tuition? What's the penalty there? Is there one?

MR. LEVY: Yale has one year to fix their problems. If they don't fix their problems by next summer, they will no longer have an accredited residency program, which means no surgical resident would want to go there, because they could never become board certified.

In addition, I'm not a lawyer, I can't testify to this, but residency is paid for. Residency salaries and the cost of residency education is paid for

by the Medicare program. It's predicated on the fact that those programs are accredited by the ACGME. If Yale's program is not accredited, one has to wonder where their funding will come from. This is a serious issue, and the ACGME does not take it lightly. However, this is the first time we know of any program losing its accreditation because of work hours.

ASSEMBLYMAN MUNOZ: Just to answer the Assemblyman's comments, when a citation such as the Yale citation comes out, the institution has an appeals process and a remediation process. And as one that actually trained in surgery at the great Yale University, I could never remember working that hard, but maybe my memory is going, Dr. Bell. But anyway, you are right that they did lose or had their accreditation. Although there is an appeals process which the school will go through and probably have some remediation, they have to show corrective actions. I mean, it doesn't happen without -- it's not a painless thing.

ASSEMBLYMAN AHEARN: So then, when in the context of New York, where it's state regulated, and there's that exception, then does the ACGME no longer watch, police? They just turn it over to the state? Is there still a--

MR. LEVY: New York has hired its own investigative agency named IPRO to go into hospitals and find out what's going on. It turns out that many residents are asked by their attendings to lie about the resident and the amount of hours that they work during residency. And so the investigative agency needs to go in and look in patient records and see what's going on and to find out if residents are prescribing medications, ordering tests when they're not supposed be there.

ASSEMBLYMAN AHEARN: Where I'm going here then is within a system where the state is policing this, as opposed to the ACGME, if the state were to find violations, would that impact the school's accreditation, as Yale potentially could be impacted if they don't comply with whatever the standards the ACGME is setting?

MR. LEVY: My guess would be probably not. In New York, the regulations affecting most of the specialities are more stringent than the ACGME guidelines. So, even if a hospital program was in violation of the Bell regulations, that doesn't necessarily mean they're in violation of the ACGME regulations.

ASSEMBLYMAN AHEARN: Okay.

ASSEMBLYMAN IMPREVEDUTO: Could I ask you to begin to sum--

MR. LEVY: Sure.

ASSEMBLYMAN IMPREVEDUTO: We have lots of other speakers.

MR. LEVY: In summary, the American Medical Student Association would like to thank both Dr. Munoz and Mr. Impreveduto for introducing Assembly Bill No. 1582 (*sic*). You could very well become only the second state in the union to limit resident work hours legislatively. It's a solution that is long overdue across the nation. Residents and patients are both impacted negatively by the hours that they work.

I understand that you asked me to keep my testimony to this bill. The one thing I did want to mention was that there is another bill in the Assembly that would make it a crime if someone has been up for 24 hours and caused a fatal car accident. It's Assembly Bill No. 1347. If that bill passes and

your bill doesn't, many residents may turn out to be criminals in the years to come. That's something that can't be allowed to happen.

So, again, we thank you for introducing this bill. I have plenty of time to stick around and answer any questions that any of you would like to pose.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

ASSEMBLYMAN MUNOZ: Through the Chair, just a question or a comment. You really probably can't answer this, but we should get it on the record. Yesterday in the New Jersey Legislature, we acknowledged the great field of nursing, and being married to a nurse, they're wonderful people. And also, it came out by, you know, part of the resolution that there is a dire shortage of nurses in the State of New Jersey.

Now, if you ran a hospital, let's say, we pass this law. One of the things we're going to hear about is, "You know, it might cost the hospital money that, you know, maybe could go to try to recruit nurses." So, you end up that you maybe can comply with the doctors not being too tired, but, you know, not as many nurses as we need. And I think we are going to hear from hospital people, if not today, in the next, you know, weeks of hearings, that kind of issue. And I'm not excusing it, I'm just saying on the one hand we talked about it, you know, the problems in nursing, realizing that federal and state governments are limited of how much money they're actually paying institutions.

ASSEMBLYMAN IMPREVEDUTO: Before I go on next, do any of you have any questions for Rob? (no response)

If not, thank you.

Dr. Bell, how did it affect the hospitals in New York, financially?

DR. BELL: (speaking from audience) Well, what happened--

MR. GURMAN: Could he just--

ASSEMBLYMAN IMPREVEDUTO: This is being recorded so we need you up here.

ASSEMBLYMAN MUNOZ: Yes, you have to do it with the mike.

ASSEMBLYMAN IMPREVEDUTO: We need you up here.

DR. BELL: What happened was that Governor Cuomo and, in particular, the late Dr. Axelrod, who was the Health Commissioner, recognized that this was a big financial burden. So, what they did was they gave the hospitals -- I don't want to be held to this 100 percent -- but let's say over an eight-year period, the total was \$2,200,000,000 in order to comply with the regulations. The problem, again, has to do with self-regulation.

The money was put into what in those days was called the reimbursement rate, and the hospitals then used the money for other things, then seeing that nurses were well-paid, that you had transporters, that you had appropriate nurses' aides, that you had people to clean the beds, and so on. So that I would strongly recommend that somebody comes up with more money for the hospitals, but its got to be designated and policed.

ASSEMBLYMAN IMPREVEDUTO: Thank you, doctor.

Normally, I'd like to get to someone who's on the other side of this, but I understand that the person that needs to testify next is here, and he needs to go back to his position. He's a resident here. Dr. Paulo Pinho.

PAULO PINHO, M.D.: Good afternoon and thank you for allowing me to speak.

My name is Paulo Pinho. I'm currently a third-year Med-Peds resident here at University Hospital. Our rotating hospitals are also the VA and Hackensack Medical Center.

Just so you know a little bit of background on myself, I was also a medical student at New Jersey Medical School. So I'm familiar with all the different residency programs that exist here as well as some of them at Morristown and Bergen Regional.

And, you know, I know about the hours that we work and, you know, I've known, since a medical student rotates to all the departments, all the different hours that we're asked to work, at times a 36-hour shift without the ability to sleep. But recently, I guess -- and the reason why I'm up here to speak is because I've had the privilege of also working in a department that has made some changes in terms of the resident work hours arena.

As a resident in the Department of Medicine, I've seen things happen in the right direction over the last two years. The Department of Medicine established an elaborate night float system in an effort to cut down the amount of hours that residents spend in the hospital on a given shift. It is a system that works primarily because while it ensures the quality of life of us as residents, it has also guaranteed the quality of patient care and the growth of the residency program.

Basically, the story is that residents will show up for work fresher and with a more positive attitude about the work that they do. And this positive attitude is going to translate into sounder medical judgement, more expansive differential diagnosing, and the desire and time to supplement patient care with reading of medical literature. And we are in residency because of the fact that we want to continue our education for medical school.

Patients are ultimately at the receiving end of all of these benefits. And, you know, I guess my contention is, you know, what patient wouldn't want the sharpest mind and the freshest hands working on them.

I'm proud to see that my State has begun to take strides on the work hours legislation issue. There are many programs around the United States that have proven that, if done correctly, night floats, day floats, resident education, protected time, equals healthier patients, healthier residents, and a healthier medical community.

Thank you.

ASSEMBLYMAN IMPREVEDUTO: Thank you, doctor.

And certainly I'm happy to hear that.

ASSEMBLYMAN MUNOZ: A question, through the Chair. Actually, thank you for coming forward. That shows great courage on your part.

You mentioned something, your department, you're a Medical-Peds resident, let's say, at this medical school. Is your department -- you're not a witness -- basically complying then with working under 80 hours? It sounds like they are.

DR. PINHO: Yes, we are.

ASSEMBLYMAN MUNOZ: All right.

DR. PINHO: And it does work. And, you know, one of the big issues, obviously, is also continuity of care, but, you know, with the night float system, adequate turnover, continuity of care does happen. And I think it has impacted on the program. The quality of morning reports is better. I think the quality overall of patient care is better. So, it's something that definitely does work.

ASSEMBLYMAN IMPREVEDUTO: I'm happy to hear that our hospital is doing that.

DR. PINHO: Thank you.

ASSEMBLYMAN IMPREVEDUTO: Thank you very much.

Our next witness is former New Jersey Department of Health Commissioner, and among many other things -- architect, aerospace, medical, whatever it is -- Rick. We've had a discussion last week about his aerospace medicines.

Dr. Richard Goldstein.

J. RICHARD GOLDSTEIN, M.D.: Thank you, Chairman Impreveduto, Assemblyman Munoz, members of the Committee. I'm Dr. Richard Goldstein, President of the New Jersey Council of Teaching Hospitals.

We greatly appreciate the opportunity to provide comments on A-1852. We applaud the sponsors for raising the issue and holding this hearing. Clearly, our Council is absolutely supportive of the fundamental concepts that our resident physicians not be abused with sleep deprivation. We've reviewed the legislation and examined the positions of other associations, including New York, and we, in the process of polling our members for their interest in this bill, and we have learned that a few of them do oppose it or some features of it. They have raised some concerns, but we're here to listen and learn. We believe it was premature for us to take a position opposing the bill. We want to hear all sides, and we want to work with the sponsors to gain the support of our members.

So what are the concerns of my members? First, we're absolutely, as you're not surprised to hear, committed to medical education and medical safety. Our members are spending millions of dollars to introduce

computerized physician order entry systems, to address pharmaceutical patient safety issues, identified recently by the Institute of Medicine. We all take patient safety very, very seriously.

We also take medical education very seriously. Our 12 members train almost 47 percent of the residents in the State of New Jersey. More of the specialty training programs are considered separately. UMD is a member of our Council, UMDNJ. Cooper University Hospital, Robert Wood Johnson University Hospital, Hackensack University Medical Center, Atlanticare, Meridian are members of our Council. We include all three of the State's Level I trauma centers.

We believe that teaching hospitals play a very significant role in the quality of life in New Jersey by providing the most sophisticated tertiary care available. So, we would be the first to concur that the training of a resident physician has become more strenuous over this decade as a function of managed care with attended shorter lengths of stay, admissions reserved for more acutely ill patients with higher levels of severity of illness, and nursing shortages.

And certainly no one can dispute that a fatigued, overworked resident is unacceptable. Fatigue poses a danger to the resident, including increase risk of being in an auto accident, suffering depression, and giving birth to premature infants. Fatigue also poses self-evident risk to patient care. The issue, however, is made more complex by the need to provide a meaningful medical education training experience, including continuity of patient care, safe and effective patient care as well as provide for the resident's safety.

From the New York experience, the first and only state to adopt a law where duty hours are regulated, we have learned that mandatory duty

hour restrictions can have unintended consequences. They can impose moral and ethical dilemmas for residents when deciding to leave the hospital, including concerns about leaving patients at critical junctures in their care, regard for the workload of colleagues, and uneasiness about the educational consequences.

What starts out as a straightforward duty hour issue addressing resident fatigue quickly becomes a conundrum effecting patient care and the educational experience itself. The enforcement of a cap on duty hours or time off by penalties is by itself an insufficient tool to ensure that a resident physician does not become exhausted while learning and providing patient care.

Some training programs, such as surgery, are inherently more demanding than others. There's a culture within some surgical specialities that insist on working a minimum of 100 hours per week and supervision and backup systems are equally if not more important than duty hour restrictions to ensure that residents are sufficiently alert to function properly. In this environment, guidelines and standards that restrict duty hours based upon this specific training program are more appropriate than general regulations that apply to all programs. Voluntary standards appear to be more appropriate than a statute.

In addition to government, there are many stakeholders involved in this training of residents. These include accrediting organizations, the program, the sponsoring institutions, patients, the general public, and the medical students and residents.

There are two predominate accrediting organizations involved in residency training. The Joint Commission on Accreditation of Health Care

Organizations, also known as JCAHO, is the principle accrediting organization for hospitals. JCAHO recently revised their supervision standards for residency training, but did not institute specific duty hour limitations on resident trainees. Instead they deferred to the Accreditation Council for Graduate Medical Education, which you've heard mentioned earlier, ACGME, which is the primary accreditation body for all 27 residency training specialities.

Virtually all State medical licensing agencies maintain, as a condition of a physician licensure, the completion of one or more years in a residency program that is accredited by the ACGME. And they provide standards for voluntary duty hour restriction in context with other standards. However, one state, Illinois, specifically compels hospitals, by statute, to comply with the resident physician duty hours of the ACGME, and this could be an alternative for the sponsors.

ACGME is responsible for evaluating and reviewing more than 7700 accredited education programs in 110 medical specialities and subspecialities. They develop standards for duty hours, program resources, and facilities, as well as an educational content, teaching activities, patient care responsibilities, and supervision. Compliance is measured through on-site inspections, including interviews with residents, with every program being visited, on average, 3.7 years.

ACGME has institutional requirements which are similar to three of the institute restrictions proposed in A-1852. They require no more than every -- call no more than every third night, requiring one day off in seven, and limiting shifts for emergency medicine residents to a maximum of 12 hours. We have no disagreement whatsoever with those three rules. Our concerns are

related only to the 24-hour duty day and the averaging of 80 hours per week over four weeks.

New York State recently adopted these regulations that cover much of the same ground and has learned that it is extremely difficult for the teaching hospitals to comply with all of these rules. And they're trying very hard to be in compliance because noncompliance comes with a heavy fine. It is extremely important that we understand the situation in New York before New Jersey adopts similar restrictions. The goal, obviously, is to improve and not complicate the situation.

The main difficulty with the duty hour restrictions is with the 24-hour duty day. More than one-half of the New York hospitals had violations and with the 80-hour limitation, particularly as it effects surgery.

Residents-in-training are needed to provide a continuity of care. A surgical resident cannot quit a case because the case becomes complicated and takes longer than envisioned, violating the 24-hour duty cap. An obstetrical resident cannot quit during delivery.

So, our support for a 24-hour cap does not necessarily apply to surgical residents or to all programs. New York State allows for three to four hours of transitional time over the 24-hour duty day for residency trainees, and even this extra time has not completely resolved the issue. We believe, however, this type of flexibility is necessary to protect patient safety and the educational experience. Clearly, ongoing supervision is a critical aspect of any residency training program and, obviously, any resident that is unduly fatigued should not be having patient care responsibilities.

The 80-hour per week, averaging the 80 hours over four weeks, appears to have been more than fair and reasonable. Yet, actual experience in

New York and elsewhere is demonstrating that some disciplines, such as pediatric surgery, are unable or, at least, unwilling to comply. Unlike other types of health-care professionals, some residency training programs must be generally available for work scheduling 24 hours a day, seven days a week because of the randomness and urgency of their patients or because some specialities require increased knowledge and procedural efficiency be attained during the time they spend in the institution.

In order that they receive exposure and experience performing the complicated procedures and examinations required to graduate a competent physician, teaching hospitals must be granted a certain degree of flexibility in creating a schedule that meets both educational and patient care needs, as well as addresses residency fatigue.

Residency trainees may be in the institution more than 80 hours during particular weeks in particular programs. While NJCTH, New Jersey Council of Teaching Hospitals, does not condone institutions abusing such flexibility, we do believe this flexibility is necessary to ensure their being able to provide a proper and complete education to their resident trainees.

In conclusion, we must all recognize that what we are discussing here is mandating duty hour rules to avoid fatigue without consideration of the impact on medical education and continuity of patient care. To accomplish all three objectives will not be resolved by absolute restrictions on duty hours that require trainees to be issued time cards, but by proper supervision and ongoing monitoring by the existing accrediting organizations. To attempt to eliminate fatigue will affect the other two objectives and may or may not eliminate fatigue. There are two national accreditation programs, as I

mentioned, JCAHO and the ACGME, that addresses these residency training issues in a more balanced and nuanced way.

Finally, because the New York law restricting residency trainee duty hours has resulted in extensive noncompliance, even in the face of large fines, it appears to be an untenable strategy. Setting absolute standards in statute to restrict duty hours, however well intended, will create other problems in patient safety and medical education of an equal or greater magnitude for some speciality programs.

We would also remind lawmakers that there is a competitive market for residents seeking training programs. Residents communicate freely across the country, and an abusive program will not attract top applicants. A program that abuses residency trainees is a failing program and will be cited for other reasons and will either be fixed or curtailed.

So, whatever your conclusions on the need for mandating duty hour restrictions, and we, like you, are here to learn. Be assured that the Council and its members share your concern for patient and resident's safety. And should the evidence and the documentation support a legislative solution, we'll be the first to support it as well.

ASSEMBLYMAN IMPREVEDUTO: Thank you, Dr. Goldstein. If you would just remain there for a couple of questions, just so I understand.

You're in support, I think?

DR. GOLDSTEIN: Of three of the five rules.

ASSEMBLYMAN IMPREVEDUTO: Of the legislation, as long as it doesn't include surgery and OB/GYN? Is that --

DR. GOLDSTEIN: The problem appears to be primarily in surgery and not OB. The surgical disciplines are the ones we're hearing from

that have the most difficult time with this. And other disciplines, internal medicine, have an issue on the 24 hours, and it's real simple to understand their problem.

The resident starts on one day, making rounds at 6:00 a.m. He's on-call that evening, and the following morning it's time to make rounds again at 6:00 a.m. He's not available to make rounds for that next day to see the patients he admitted that night. So, New York has a transitional period of three to four hours, and it's that kind of flexibility. New York also feels hampered by regulations in this area where, you know, if it's 23.5 hours or 24.2 hours, bam, they're cited. There's no give-and-take here. There's no flexibility, and there is no ability for the resident physician to make their own decision as to how fatigued they are, whether or not they finish their 24 hours, and they want to attend a lecture, they don't want to attend a lecture. These are adults and without understanding, the people could put pressure on them to attend, and they are fatigued. It's a dicey issue to resolve, but somehow within this context we would like the residents to be able to, if they are fatigued, to go home and if they're not fatigued, to hang around.

ASSEMBLYMAN IMPREVEDUTO: Let me ask, Dr. Bell.

If you could just stay there, I just need-- I just wish there was another system we could do this. We don't, and I apologize for that. But we've heard something about New York, and you are an expert on New York, sir.

DR. BELL: I hate to say this to this man here, but I have been listening to this stuff now for 20 years almost. He is not presenting me with any data in what he says. He does not work in New York. This is known as palaver. The word is p-a-l-a-v-e-r. Everybody in this room now, I demand, as

the distinguished university professor, to look up as to what the word palaver means. He hasn't presented us with anything.

I am telling you that while the system has had problems in New York State, people are now complying. They're complying not because of anything that he said, but because the public demands this. And when he talks and other people talk about continuity of care, no one has ever paid a resident to take care of them. The person who is responsible for the continuity of care is the person who's being paid. It's called the attending physician.

This system has worked wonderfully in New York. And, I mean, I sometimes come over the bridge, but I'm going to give him some money so he can come over the bridge. He's welcomed to come to our place to look at our surgical program, which is a class program, or any of the ones in our system at Einstein. He could look at any one of the programs.

People are now complying, and they know that it's good for the young doctors, and they know that it's good for the patients. And this is what's going to happen no matter what people are saying here in New Jersey.
(audience applauds)

ASSEMBLYMAN IMPREVEDUTO: Assemblyman Munoz.

ASSEMBLYMAN MUNOZ: Thank you.

ASSEMBLYMAN IMPREVEDUTO: Ladies and gentlemen, while I know that some of the fervor may run high, this is a legislative hearing.

ASSEMBLYMAN MUNOZ: Absolutely.

ASSEMBLYMAN IMPREVEDUTO: And we require decorum. In all legislative hearings, there's no applause, chanting, or booing.

Thank you.

DR. GOLDSTEIN: I'll be glad to provide--

ASSEMBLYMAN MUNOZ: Just, through the Chairman, I want to, actually, first of all, thank Dr. Goldstein for coming. Maybe just for the audience, the major hospitals of the Council of Teaching Hospitals, you know, give us four or five names so that the audience understands--

DR. GOLDSTEIN: University Hospital, here; Robert Wood Johnson University Medical Center; Hackensack University Medical Center; Overlook; Morristown; Meridian; Jersey Shore.

ASSEMBLYMAN MUNOZ: So those are probably some of the better known institutions in New Jersey.

Let me just address, you know -- and I think you're going to hear a lot of different parts of these testimonies. The continuity of care issue. Okay, I'll give you an example, a practical example. On Sunday, I worked here at the hospital and then, I think, at 8:00 a.m., I came off duty, and we actually had a person we had operated on all that night, and I left to go to Trenton. I had to be in Trenton to be a State legislator as of 10:00 a.m. And I know that I left several residents -- there was another attending that came on, of course -- but there were some other residents directly involved in that person that probably stayed until 10:00 or 11:00 that morning. I think we violated our 24-hour rule, but, you know, that was under the continuity of care type thing.

You have the thoughts, you did mention that. Would it have been better, do you think, for us to just remove all those residents?

DR. BELL: (speaking from the audience) I don't think it's done that way, doctor.

ASSEMBLYMAN MUNOZ: Pardon?

DR. BELL: I've never heard anybody leaving--

ASSEMBLYMAN MUNOZ: But--

DR. BELL: The word is responsibility. Nobody does that.

ASSEMBLYMAN MUNOZ: This is not the operating theater.

Dr. Bell, you can't shout from the audience here.

But, through the chair, you've seen it. So, doctor, you've got to learn. But in any event, just give us your thoughts. This patient was now in the ICU, but we had a pretty complicated surgical situation going on with the person.

DR. GOLDSTEIN: Well, I think you're hitting the nail on the head and, in this regard, let me simply quote from the ACGME on their general surgery requirements, "Graduate education in surgery requires a commitment to continuity of patient care. This continuity of care must take precedence, without regard to the time of day, day of the week, number of hours already worked, or on-call schedules." That's where the ACGME is coming from. As was read earlier, "At the same time, patients have a right to expect a healthy, alert, responsible, and responsive physician dedicated to delivering effective and appropriate care."

The debate is that pendulum, defining the line where the continuity of care versus having an effective, alert, and responsive physician. That's what we're talking about here. And our only point is that as soon as you legislate it in the statute, and one day is 24 hours and not 24 hours and 2 minutes, then you are interfering with the balance in the medical education.

And that we are simply saying that from the New York experience, and we have a substantial amount of information from New York's teaching hospitals, as gathered by the Greater New York Hospital Association, and we'd be glad to share that. They simply compile all the citations and fines and get the views of those hospitals and our membership so that they can advocate the

same way we advocate. And they say the two problem areas are the 24-hour rule and that average of 80 hours a week in time, primarily, as it effects the surgical disciplines, primarily. That seems to be the key area. Dermatology does not seem to be a problem.

ASSEMBLYMAN IMPREVEDUTO: No one dies, no one gets better.

DR. GOLDSTEIN: Right. Or psychiatry. (laughter)

So that the problem we're addressing is related to a few of the programs and, to some extent, within those programs there is a culture within that physician environment that says, "This is the kind of way we handle our lives. This is the way we work. And if this is the -- you know, what you like to do then this is the program for you, and if not, not." And they take that kind of an attitude.

We're certainly not trying to do that here. We're simply trying to gather all of the information that we have available to us to present the concerns that we've heard raised and to discover what is the most proper way to proceed.

ASSEMBLYMAN IMPREVEDUTO: Dr. Bell, I think you wanted to comment on the continuity of care?

DR. BELL: First of all, I have never, ever found anybody who is responsible and involved in patient care to leave because of what is being referred to, as it was referred to 20 years ago, as a time clock mentality.

Doctors do not function with a time clock mentality. If someone is mandated to be 24 hours -- I've yet to meet anybody. I've been doing this for a long time -- who looked at his clock and said, "I got to leave because the

law says 24 hours.” People stay around as long as they’re capable of taking care of their patients. That’s responsibility.

This is something that I’ve been listening to for a long time. I’m sorry that I’m impatient. I’m getting old. And I can’t stand listening to this anymore. I’ve yet to ever hear anybody leave an operation saying, “It’s 24 hours, I’m leaving,” or “Don’t show up to take care of the patient” and so on.

ASSEMBLYMAN IMPREVEDUTO: How would New York handle that? Or how would we handle that? If a young person is a medical resident and they’re in their 15th, 16th hour of work and the law says you can only be there for 24, how does that--

DR. BELL: It works very simply in practice, all right. First of all, I take care of patients. I’m responsible. I have a number of wonderful kids. The residents and the medical students keep me young. I work with them all of the time. They understand responsibility.

Let’s say that someone gets sick -- this doesn’t happen very often -- but let’s say that somebody needs to tell me about something in the morning, they will either call me at home -- you know, there’s a telephone. These people have cell phones. I haven’t got one yet, but I’ll get one, one of these days.

ASSEMBLYMAN IMPREVEDUTO: It’s a great invention. You ought to try it.

DR. BELL: Anyhow, the point is that people stay around to do what they’re responsible to do. I’ve had people come around-- For example, you were talking about the 24-hour thing. What happens? We have a night float system, so it happens much less. But in the beginning, people would be there in the morning who had been up. Now, for example, the night float person would come around, the first person we’ll see would be the night float

person. The person's been up, and we would make rounds and listen to what's going on, and the person then goes home. But no one leaves because it says 24 hours. The word is responsibility. And I'm telling you this does not go on in programs where that's emphasized.

ASSEMBLYMAN IMPREVEDUTO: So, no one -- if that person was there longer, the hospital police are not going to come in and --

DR. BELL: But they were discharging what they're supposed to be doing, which is taking care of patients.

Well, if the person was ready to die -- talking about the resident -- and he couldn't do that. He fell into the operation like Rob's talking about. That we don't want. This doesn't happen very often. It's just -- you know, people go -- I have a curve as well as regulations, you know, the Bell-shaped curve. He's talking about four standard deviations out. I mean, I listen to this.

DR. GOLDSTEIN: Let me simply comment that based on your comments, Dr. Bell, we're in agreement. If you could write in this legislation that the resident is entitled to be responsible, then we're not going to have an issue.

DR. BELL: (speaking from audience) We do that as teachers.

DR. GOLDSTEIN: Fine, but if the State's going to come in on 24 hours and five minutes and say, "You owe me \$2500," then we have a problem. And that's what we're talking about here today. We're not talking about the responsibility of a resident, we're talking about mandating duty hours.

ASSEMBLYMAN IMPREVEDUTO: Questions for Dr. Goldstein?

ASSEMBLYMAN MUNOZ: Through the Chair, again. I was at a surgical meeting recently. We're talking about this, among academic surgeons, you know. And the question was, will there be a way that the State -- you know that we have the State Health Department. We have various panels that review care. Would there be a way for the State to track -- you know, let's say some law like this was passed and let's say there was, for certain specialities -- and I'm going to use the word flexibility -- but is there anything that exists, currently, in our state? And I thought there probably was between the health department and different collectors of data, the hospital association. You actually could probably try to tell whether you have adverse events, you know, or a change in adverse events? Kind of complicated.

DR. GOLDSTEIN: I think what you're suggesting is difficult. The ACGME does track resident duty hours according to the programs that are involved, and you may not have different standards for these programs. The Health Department separately would be tracking accidents and untoward events, drug events, etc.. I don't think there's any way to connect the dots that this accident was caused by a fatigued resident, if that's what you're driving at.

ASSEMBLYMAN MUNOZ: You know, I guess if we can give visas to people that, you know, do certain things, then, yes, they've got hope, but, I mean, in a perfect world--

DR. GOLDSTEIN: Right.

Well, that's one of the things that is missing, and there's the context of what is the problem that we're fixing here, as to how many untoward events have there been in New Jersey? Are our programs more or less in sync with the ACGME guidelines, or do we have abusive programs?

And it's really that kind of information I'd be most interested in hearing today. You know, a California resident is falling asleep while doing surgery. Is the California resident in an abusive program? I just don't know, you know, what our program -- what abuses are here? I haven't heard of this internally within our Council, and that's one of the reasons that we want to be educated. If there's a need for mandating legislation, we're going to be in favor of it.

ASSEMBLYMAN IMPREVEDUTO: Assemblyman Ahearn.

ASSEMBLYMAN AHEARN: Yes, sir.

You mentioned earlier on the cultural aspect of the surgery -- surgeons. How much of that is a necessity based on the real work, and how much of it is a cultural kind of, you know, Tom Wolfe, *Right Stuff* attitude where the surgeons -- "and if you can't hang for 100 hours a week, we don't want you," kind of mentality?

I've seen that in my experience in trained sleep deprivation. Somebody made a reference earlier to combat training. My background was with the Special Forces and Rangers, and I can understand how you feel after four or five days without sleep to the point where you hallucinate. Now, I can't understand what, within the concept of surgery, in my mind as a lay person, could ever even justify some sort of culture where going 100 hours without sleep is a good thing. I don't understand.

DR. GOLDSTEIN: Yes, and I can provide you with some information on that, but I don't happen to have it with me. There are a number of quotes by a surgeon that does play a role in the ACGME surgical area who, in my opinion, his position is like the cowboy position. He is arguing that there is a culture here, and this how the program works.

Now perhaps Dr. Munoz would comment. He is a surgeon, and he could tell us much more about the culture of the surgery than I can.

ASSEMBLYMAN MUNOZ: Well, you know, I would only comment and say that -- you know, I'm on the ballet board. If you look at the average ballerina in New Jersey, it's probably somewhat different than the average surgeon. You know, I'm a whole lot bigger than the average ballerina. But, you know, you do have certain personalities that are attracted -- you know, people want to be governor, people want to be school teachers. I think that surgeons, in general, probably are generally, you know, fairly proactive people. You know, when you think you're coming under the knife, and if your surgeon sits there wringing his hands about not sure what to do, it doesn't give you great confidence that you're in the right spot.

I mean, you know, you can't typecast people, but I think lots of different physicians, just as other, you know, professions, you know, are typecast. I really don't think there's any culture though, and I'll go back to what Dr. Bell was saying before. We are, you know, sworn under the Hippocratic Oath to try to save people's lives. And I don't know a single colleague or educator that wants to violate that principle. I really mean that. People do not want to hurt people. It's extremely distressing when that happens.

DR. GOLDSTEIN: Right.

Well, I certainly concur with that, and I'm also a physician. I would say this to the lay public, that if you really have the ability to analyze the personality profiles of the physicians that make up specialities, you would find that internally within the specialities they are more alike than not alike, that there are personalities that go into psychiatry, there are personalities that

go into neurosurgery, there are personalities that go into cardiology. And when you go to the conventions you're able to understand exactly what I'm talking about, or even hang out with them. You'll find them very different kinds of people.

And so I think when it comes to medical students seeking residency programs, in addition to the intellectual satisfaction they might have with that speciality, part of it, I think, is their comfort with the colleagues that are already in that discipline. And I'm simply saying that for whatever the reasons in the discipline, certain disciplines, a 80-hour week, a 100-hour week, or a 200-hour week would have absolutely no meaning. That they are there, there's a job to be done, they're going to get that job done, and they don't want to hear from anybody else as to how they go about doing it.

ASSEMBLYMAN IMPREVEDUTO: First, I just want to -- I was wondering why you were running in Trenton with those funny shoes on last week. The second thing is -- and I said this to you in a couple of our dinner meetings last week or two weeks ago -- I don't know if I want to be on the other end of that medical decision or that surgeon's knife who's been up for 24 hours or who's been working for 90 or 100 hours in that week. I'm not so sure I want to be that patient.

DR. GOLDSTEIN: Well, the key here is supervision. Nobody wants to have an exhausted physician. And, generally, the exhaustion is coming when they make rounds the following day. It's really the transfer of information. But I agree with you totally. I was an emergency physician. I worked 24-hour shifts, and there is no way that the patient who is coming in with an MI at the 23rd hour is getting the same care as when I just began work.

ASSEMBLYMAN IMPREVEDUTO: And I think that's exactly what we're about.

DR. GOLDSTEIN: So, I think, that's very important.

ASSEMBLYMAN IMPREVEDUTO: And it's exactly what this piece of legislation is about.

DR. GOLDSTEIN: Well, but one's exhausted at 20 hours, too, if you've been up and going. So, the point is that once you have these cutoffs -- we measure fatigue in human beings according to a clock, and the clock may not reflect how fatigued they are, it doesn't account for whether or not they got rest during that evening.

It's a complicated formula, and we're simply saying that the supervision of the resident is the most important factor. And that compliance with the guidelines that are out there are important. So, there are the certified agencies that do this and, as apparently at Yale, they found them noncompliant. Plus, the public is spending more time and attention on this matter and therefore these residency and supervision programs are paying more attention to these kinds of matters. So, just raising the publicity flag and pointing a finger at it has already served the public well.

ASSEMBLYMAN IMPREVEDUTO: Rick, before you leave, the next question I have is, we would like a copy of your testimony if you can give us that?

DR. GOLDSTEIN: Yes.

ASSEMBLYMAN IMPREVEDUTO: And secondly, is this really a matter of money? Are the hospitals here in opposition to any of this stuff because of -- how do we afford to do this? Do I need to get another surgeon? Do I need to get another, you know--

DR. GOLDSTEIN: No. No. No one has ever raised a concern of cost as regard to these restrictions, not a factor. I'm actually convinced the residents are working harder than ever because of managed care and other situations going on in hospitals.

ASSEMBLYMAN IMPREVEDUTO: So, for the record, cost is not--

DR. GOLDSTEIN: No, I don't see any cost of meeting these guidelines. No.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

Anybody else? (no response)

Dr. Bell, thank you. I know that you have to go now. I appreciate your assistance in this.

DR. BELL: Thank you.

ASSEMBLYMAN IMPREVEDUTO: Okay, I'd like to ask Dr. Richard Bonforte, Jersey Medical Center.

Doctor, usually we have sheets for folks to fill out, and they tell us whether you're in opposition or support, so I don't know what--

RICHARD J. BONFORTE, M.D.: I will take a neutral position at this point.

ASSEMBLYMAN IMPREVEDUTO: Okay. And that's a good position to take in front of the sponsor of the bill.

DR. BONFORTE: Assemblyman Impreveduto, Dr. Munoz, Mr. Ahearn, I want to thank you for the opportunity to allow me to testify today.

I'm the Senior Vice-President for Medical Affairs at Jersey City Medical Center, and in the capacity, responsible for the 89-plus residents we have in a number of programs at the Medical Center, including internal

medicine, pediatrics, obstetrics, surgery, orthopedics, emergency medicine, and ophthalmology. Our affiliation is with the Mount Sinai School of Medicine, but we share responsibility for some of our training programs with the people here at UMDNJ, as well as the Saint Barnabas Health Care System. I'm also Vice-President and Chairman of Pediatrics; in that capacity, responsible for 21 residents in my own program.

I don't want to belabor the Committee with repeating much of what has been said already. In essence, I support Dr. Goldstein's comments about the need to look at this in a less emotional viewpoint and looking at the implications of the rigidity of the legislation as it currently exists.

I think the Committee should know that I've spent over 25 years as a Professor of Pediatrics in New York State, so I'm very well familiar with the Bell Commission. And there's a lot of emotion associated with that and, I think, as much as good that has come out of that in terms of dealing with resident stress, patient care issues, all of which are paramount. Certainly, I'm not in opposition to, but I think with the lessons we've learned from the Bell Commission report, relate to the issues of supervision. And these issues of supervision should be paramount in any legislation that's put forth by the New Jersey State Assembly.

Despite Dr. Bell's comments, this area still is not the one that gets focused on, okay. And when the bean counters come in from IPRO and start looking at charts and looking at schedules, etc., they count up with calculators and total the number of hours.

I've just returned from a four-day meeting of the Pediatric Program Directors, our annual program review, and this topic obviously has nationwide concern, but it's that one argument that keeps constantly surfacing

-- the concern that really what gets looked at is the total sheet. I would support Dr. Goldstein's statement that we really need some flexibility in dealing with that. To lock in 80 hours means that someone comes in and totals up 80 hours and if you're at 82 hours in a given area, you get dinged, okay. And it becomes -- that's what's really critical. And I think we need to look at this in a more balanced viewpoint.

I think the Committee also should be concerned. That is, while we focus on resident hours and the totality of time spent, what we found in our own health care system -- and I can tell you what I found in my time in New York State -- that residents go off duty and, periodically, we encounter that they're moonlighting at other institutions. This also impacts on the total amount of time spent in professionalism. And I think an important part of any legislation that goes forth, at this point, should include a total ban on moonlighting of house officers once they leave their programs. Because this, again, is something that gets swept under the carpet and is not looked at, but does effect the totality of resident hours spent, adds to stress, and so forth. We don't often find residents are coming on duty for their term of duty, tired because they've been taking call on their day off, etc.

And I think the Committee needs to keep in mind, and we discussed this at length at our meetings, the amount of data that is available, to really look at this in a scientific method, is really quite limited. I think everyone is supportive of a need to regulate and monitor and supervise and to play up the importance of diminishing resident stress, the need for patient safety, but to do it in an environment which becomes less restrictive and not totally mandated by specific rigid rules. So, in my statement, that's my comment.

Thank you very much.

ASSEMBLYMAN IMPREVEDUTO: Dr. Bonforte, if you will, are you in agreement with Dr. Goldstein that this is not a financial issue? It's not a matter of money that you're in opposition to this?

DR. BONFORTE: I think you, gentlemen, since you sit at the State Legislature, know that anything that goes on in terms of health care today becomes a financial issue. So, to deal with that -- and I think Dr. Bell eloquently stated it just a few minutes ago -- when these laws were put into regulation, the Commissioner of Health, David Axelrod, put a huge pot of money behind this. So, I think to say that there are no financial implications would be overstating it. I don't think--

ASSEMBLYMAN IMPREVEDUTO: Well, I'm asking you. Is your opposition due to--

DR. BONFORTE: My opposition is due to the rigidity of the regulations as they currently exist.

ASSEMBLYMAN IMPREVEDUTO: Okay.

ASSEMBLYMAN MUNOZ: Through the Chair? Just a question through the Chair. Jersey City, the distinguished Jersey City Medical Center and the--

DR. BONFORTE: And we are distinguished.

ASSEMBLYMAN MUNOZ: Absolutely. The political stories that I'm now hearing in the State Legislature about Hudson County and Jersey City are mind-boggling, but the medical care there -- it is a very good institution. Do you think your residents, your 100 or so residents -- you basically comply already? I mean, give us a sense of--

DR. BONFORTE: My sense is that we do. I mean, there's always going to be some resident you will talk to and say, "Well, I worked 92 hours last week," when documented no.

The bottom line is that in the two major programs we have at our institution, internal medicine and pediatrics, the internal medicine and the pediatric RRC's are really quite tough in looking at the hours that are spent and are quite on top of this. And the penalties imposed to that are quite severe. If you're not in compliance when they do their surveys, you're cited for those. Your programs can be put on probation unless amended.

Now, the issues with surgery I think have been talked to, and there's a wide variety in that area. There are surgeons who really feel very strongly about the need to have much more flexibility than even what Dr. Goldstein may be talking about. But, I think, in general, our house staff are in compliance with the regulations as they are proposed, yes. And that was true in New York State as well, particularly in medicine and pediatrics.

ASSEMBLYMAN IMPREVEDUTO: Matt.

ASSEMBLYMAN AHEARN: Yes, through the Chair. Sir, you mentioned 80 hours a week and, you know, cut off something like that would be some sort of trigger. This legislation actually says you can't exceed an average of 80 hours per week over a four-week period.

DR. BONFORTE: Yes, but that means--

ASSEMBLYMAN AHEARN: Well, the question is, is that an 80 hours a week over a four-week period doesn't mean you can't go over 80. I mean, is it unmanageable to track 85 hours, you know, three weeks in a row, and then you give somebody a break so they can get some rest on the fourth week?

DR. BONFORTE: The difficulty of that is you're putting down -- let's say you go tag up somebody's hours, 84, 85 in a given week. That means you're going to have to do 74, 76 the following week. Okay. It's an average. But when the bean counters come in and look at that, and if somebody's over an hour because they stayed for their morning report, you get dinged for that.

So, I mean, really you need a broader definition of flexibility. I think there should be something in there about some sort of transition time, for educational conference, for sign-up. Averaging only means that you can go over one week, but you're going to get cut back the next, and you're still talking about 80 hours a week.

ASSEMBLYMAN IMPREVEDUTO: But wouldn't the argument be, at that point, even if we do have transition time and somebody went an hour over, wouldn't you have the same argument then?

DR. BONFORTE: Well, I think you would find less abuse in that situation because you would have--

ASSEMBLYMAN IMPREVEDUTO: Well, maybe more.

DR. BONFORTE: Well, you can always find more. But I can tell you from experience that the difficulty comes up with that one hour sign-out, one-and-a-half hour conference time. And the problem that the house staff face, okay, admission stays are shorter, length of stays are short for patients in hospitals, okay. Inpatient admissions are down in hospitals. So, the importance of utilizing that patient when they're in for a maximal teaching effort has to be looked at very, very strongly because patients are in for shorter periods of time. So, the need to sort of have a little bit of wiggle room, so to speak, to use those patients for educational purposes, again, under supervision.

And the important thing to consider, we already have on-site

supervision in many of the programs, particularly in the high-impact areas, is emergency medicine. We have 24-hour physician coverage in our emergency room, staffed fully by board certified emergency medicine residents at the Medical Center. The same in our intensive care units, okay. So, there are people there, and you just need some flexibility to account for the educational plans that are needed in running a program.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

DR. BONFORTE: Thank you.

ASSEMBLYMAN IMPREVEDUTO: Dr. Amy Peardon.

Dr. Peardon is with UMDNJ, Department of Pediatrics.

AMY PEARDON, M.D.: Hello. Good afternoon.

My name is Amy Peardon, I'm a--

ASSEMBLYMAN IMPREVEDUTO: Doctor, could you just lower that to you? (referring to PA microphone) There you go.

DR. PEARDON: Okay. Hello. Good afternoon.

My name is Amy Peardon. I'm a pediatric resident here in my second year at UMDNJ. I trained at UMDNJ, the Osteopathic School in Stratford, South Jersey. I'm a pediatrician, but I'm married to a urologist who went through two years of general surgery in the South Jersey hospitals, which was also in Camden. So, I know how his schedule works and mine and the practicality of the number of hours that come into this.

You may look at the number of hours and know you're meeting your 80 hours, but how are you doing those 80 hours? In pediatrics here, when you're a senior on the floor, you come in in the morning at 7:00, and you work till 4:00. That's your day, in theory. You have to sign out in the afternoon. But if I'm on-call, I will stay Monday night and then supposed to

be leaving Tuesday. Well, I'm there till sign-out Tuesday afternoon. Sign-out begins at 4:00. I'm not leaving the floor till 6:30. And then we find out that chest X-ray -- sorry, who's going to look at that chest X-ray? Who's going to do the last thing? And there are those residents that stay until every result is back, but the kids don't go home. These patients aren't leaving. You see, you feel that -- I want to make sure everything's finished. And you need a point to sign out to the next team.

So what's happening is that we're working these long shifts to the next day and you may average, over time, 80 hours. However, that works out, because on one week, I'm on-call every fourth night. So, I might be on-call Monday night and Friday night. Those are my two nights of the week. So, it's an additional 4:00 to 8:00 a.m. shift, like this nighttime, but the next week the fourth falls on a Saturday, and that's 24 hours.

So, that's how it is averaging. You do get some weeks that might have more and some weeks that have less, but the way the 24 hours is spent needs to be look out because I'm still there supervising the interns and giving all the information necessary at 5:30, Tuesday afternoon, to the night shift, whatever I remember or I'm able to pass on. So, their hours are long.

And everything comes out different in the wash, the practicality in it. Because when my husband did surgery, they told him four weekend days a month. No one wanted to work every weekend, so they worked a Saturday and a Sunday. He would be on from Friday, coming into work; on-call Friday, Saturday, Sunday; and still work Monday. So, they were working these long weekends.

So things, you know, start to change over time, but you have to look at how they're working on the one-to-one time. Our ER shifts, they

decided to put us here on for call because I'm not an intern, so I can't do intern call on the floor anymore. So, they put me in the ER to cover. I'm a cardiologist consultant by day. So, I work there 8:00 to 4:00 for the day and then I go and do call in the ER, not a shift, call. I'm there from 4:00 p.m. till 8:00 a.m. in the morning. It's a 16-hour shift. And then I go and be the Jersey City pediatrician, okay, and see somewhere in the number of 40 to 50 kids in the morning and come back and be the cardiologist in the afternoon.

So, we're being pulled in all of these different directions.

ASSEMBLYMAN IMPREVEDUTO: You are kind of losing me here.

DR. PEARDON: I'm sorry. Well, I mean, this is the nuts--

ASSEMBLYMAN IMPREVEDUTO: I lost track of where you are.
(laughter)

DR. PEARDON: Well, what happens is we end up doing our call. I was doing call in the ER as a 16-hour shift, okay. So, there's a limit in the ER to be in 12 hours. So, they're using our hours in different ways. And there's a State rule, I think, to how many hours that you're supposed to be working. Twelve hours? I don't know how that works.

ASSEMBLYMAN IMPREVEDUTO: There is no State law on anything.

DR. PEARDON: So, we're working for extended hours in acute care, having worked the day before and continuing to work somewhere the day after.

ASSEMBLYMAN IMPREVEDUTO: Let me ask you this, do you feel that, given your experience, the hours that you are currently working, there are times when you, as a medical physician, feel that you are not as sharp (a)

as you should be and (b) that you could be working to the detriment of that patient?

DR. PEARDON: Yes. There are times when I'm working in the ER, two months pregnant, and sick at 4:00 in the morning, throwing up every 4:00 in the morning for seven or eight shifts in a row that month.

Those are the long hours. Those are the things that come out. And they're shifts. Certain departments can be run differently. Some of our departments are ICUs or other things can be run with 12-hour blocks or 24-hour blocks, and you just trade off people.

Here we're on a team where there's a group of people working on days, and then we supply the fourth night schedule. So, we're not working every third night. Here it's asking for every third. We're working every fourth, but we're still working a lot, even during that overnight time. It's not limited to 24 hours.

ASSEMBLYMAN MUNOZ: Really just a comment. We appreciate your testimony.

I think it's important, and I think several of the other people have testified about the residency review accreditation process. In other words, in the United States, in New Jersey, every residency is reviewed, and those are rigorous reviews. Just like what happened at Yale, the Yale surgery program, which I'm an alumni, no one wants to have that accreditation process come in and say, "You're discredited." Because if I'm in charge of it, trust me, the next thing is you get a call from whoever you work for saying, "We have good news and bad news."

And I think that, you know, a lot of programs have been looking, including pediatrics and others, about their hours. Because I know when they

get reviewed by these national bodies, they're asked to produce schedules and their documentations. So, I want at least the members of the Legislature to know that, and there is a procedure that's in place. But what we're are talking about is should we have a State law to really help--

DR. PEARDON: Well, it doesn't seem like it's regulating that. It seems like, you know, no vacation goes unpunished. You have eight calls in a month, whether they're-- You have ten calls in a month, okay. If you take off your two weeks vacation that month, you still will have ten calls in that month, all right. So you're still doing those number of nights because they need you to give relief to the other group and the other residents in your team. So, you come back -- my husband comes back from vacation and having to do the same number of nights he would have in a whole month in those two weeks.

ASSEMBLYMAN IMPREVEDUTO: He has vacation?

DR. PEARDON: He does get a vacation, but they have a call schedule to match and fill people. And the hours, having 24 hours on and off, that's important to regulate, not just the number of hours in a week. It's how those hours are spent.

ASSEMBLYMAN IMPREVEDUTO: Where are you in the hierarchy of residencies?

DR. PEARDON: I'm a PGY-3. This is my third year of training. I did an internship in osteopathic medicine. I'm in pediatrics in Stratford, New Jersey, and this is my third year.

ASSEMBLYMAN IMPREVEDUTO: I'm sorry, were you a third year, second year?

DR. PEARDON: I'm a second year in this program. It's a three-year program.

ASSEMBLYMAN IMPREVEDUTO: Three-year program. So, after three years, you then will be out on your own doing whatever it is--

DR. PEARDON: I'll be out on my own, yes, working.

ASSEMBLYMAN IMPREVEDUTO: Okay, so you have another year in this. Does it get more difficult, more time-demanding as you go forward?

DR. PEARDON: Yes, it does. In our program it does, the way it's designed because we work as the senior, as third years, and not as second years. So, on a evening, I may be supervising three wings, three sections of the floor, and there's an intern on each floor. So, when the interns divide the work that's fine, but when the senior does it, we're doing all the work for all those three.

ASSEMBLYMAN IMPREVEDUTO: An intern is a first-year resident?

DR. PEARDON: Yes.

So, what's happening is I'm supervising all three of those residents. So, I watched them last year going, "Oh my gosh, how am I going to keep up with all those, you know, three different people going on." So, there's more responsibility, and they choose to have that in the hierarchy of my program as a third year. Some places do it mostly second years, and they give you more elective time in specialities as third years. It's just a matter of how the program runs it.

ASSEMBLYMAN IMPREVEDUTO: Forgive my ignorance, but while you're doing this the patients that you're overseeing in the hospital, each

of them have their own personal physician, correct? The attending physician, I guess, is the terminology.

DR. PEARDON: There's an attending at this hospital. There's an attending assigned to the floor or to one wing. So they come in and make some rounds with us in the morning, and they're our supervisor for that group.

In other hospitals, like Hackensack, they're private pediatricians who admit to that hospital. So we're working with lots of different people who really have a one-on-one person, like your child is being admitted to your own pediatrician who has privileges there. They can come and go and write their orders. So, in that hospital, I'm following all of these general pediatricians around.

Here there's more of an attending of service. Most people get admitted -- you lose your home doctor. And when you come in here, you're taken care of by the University attending. So that gives more continuity to the situation by having one person there.

ASSEMBLYMAN IMPREVEDUTO: So there's basically one other person besides you who is kind of in charge of everybody else?

DR. PEARDON: Who's in charge. And there's a chief resident that oversees things and is part of sign-out and things like that, so they hear the transfer of information and different things that are going on like that.

ASSEMBLYMAN IMPREVEDUTO: Any other questions?

ASSEMBLYMAN MUNOZ: Just, you know, a comment, I think, for the Committee members.

And I'd like to say that the training of doctors is a little like the military, you know. It's a world of its own. And depending on which branch you look at, you know, the Air Force or the Navy or the Green Berets, you're

going to get a little different spin of it. But the change that's happened in the last 30 years in the United States has been where every person that comes into the hospital has a senior doctor in charge of that person whether you're at University Hospital or in Toms River, New Jersey. And then you're in the constellation between medical school, which you graduate, and training, which is finishing. I think that, you know, varies a little bit, but just like the military, depending on which unit you go into and where in the United States or the world, you'll get a little different spin on that.

DR. PEARDON: There's someone in charge.

But they made a comment about nursing. It does make a difference. In the ER, we're moving patients from one floor to the other. We have to admit them. I move them. I move the stretchers. They need an X-ray request, I do that. I mean, there are ways that we can get more help, and the ancillary staff would be excellent. Hackensack has some more people in the ER so I don't even know where the blood goes after I draw it. It's gone, you know, they put it out here, I walk it down the hall around the corner in the other building to bring it to the lab. So there are some things that definitely can make residents' jobs a lot easier. And I'm sure having more nursing staff on hand would, you know -- and even transport people in the middle of the night to help move patients to the floors and stuff.

ASSEMBLYMAN IMPREVEDUTO: Matt, are you-- Thank you.
Thank you.

DR. PEARDON: Thank you very much.

ASSEMBLYMAN IMPREVEDUTO: I'd like to call Dr. Jeffrey Zlotnick. Dr. Zlotnick is with the Academy of Family Physicians.

JEFFREY ZLOTNICK, M.D.: Good afternoon, and thank you very much for giving me the opportunity to speak.

My name is Jeffrey Zlotnick. I am a family physician. In fact, that's about the only residency you haven't seem to have heard from today. I'm at the Warren Hospital Family Practice Residency Program. That's in Phillipsburg. You keep going west till you just about get wet.

With apologies to Dr. Bell, I'm a PGY-18. And Dr. Munoz, I'm also a graduate of this institution here. We came out officially at our board meeting as being "opposition to the bill." And you're probably asking, why in your right mind did we do this? And I have to explain it. The only point that we wanted to make was the 24-hour rule. Otherwise, we are in total support of everything else in the bill. And I need to explain why that is.

One thing I want to paint in your mind is a very, very clear picture as to how different family practice residencies are run versus a lot of other residencies.

ASSEMBLYMAN IMPREVEDUTO: Excuse me, ladies. Please give a little courtesy to the person who's testifying.

DR. ZLOTNICK: As mentioned before, I'm going to pull out the alphabet soup here, the ACGME, or Accredited Council of Graduate Medical Education, and the RRC, the Residency Review Commission, has set some very, very strict guidelines for family practice programs, and if we don't meet them, we also can lose our accreditation. And some of these guidelines include that residents have to have very adequate backup and supervision and that includes either a senior resident and the attending has to be immediately or very quickly available for any problems or questions. We also have to have

some form of mechanism for support groups for residents. They have to have a mechanism to promote physician wellness and prevent impairment.

And on the average, going back to some of these rules here, right now, on average, the family practice residents probably work already under 80 hours a week. Our average, we even polled our residency directors, is about 60 to 70. Most residents are getting some sleep while they're on-call. And many programs, where it's applicable, have gone to a night float system where pretty much someone leaves at night, signs out, and then a night float person comes in. So those rules are not being violated at all.

Our issue, really, is the one of continuity. The concept that if you admit somebody at night, somebody has a problem, you want to follow them during the day to see what happens. What did this turn out to be? Was his chest pain an MI, or was it reflux? What happened with the person with the abdominal pain? Our residents really do want to follow and find out what happens to these people, and they get to know. And if we have this absolute strict cutoff at 24, it could be a problem with that.

So, the other issue we wanted to talk about too was educational conferences. I am the Director of Medical Education at Warren Hospital, and I schedule a number of conferences that occur, and they all occur basically during the day. If you have that strict 24, residents could "not be able to go to that conference." And a lot of them want to come to the conference because this is where we bring up a lot of newer educational opportunities and to listen and learn. And they would lose their ability to do that.

Now, where did we get this opinion from about dropping this 24-hour rule? This was not a bunch of old guys sitting around a room saying, "I went through it, therefore, you got to go through it." Thank God we don't

think that way. What we came up with this thing was, our national academy, the American Academy of Family Physicians, has a board of directors. On that board of directors sit two full-time residents. They are part of a commission on residency affairs. They came together with a paper that they put together this January on rules regarding residency hours. And pretty much they said everything you said except for the 24-hour rule.

ASSEMBLYMAN IMPREVEDUTO: Can we get a copy of that?

DR. ZLOTNICK: Yes, I have a copy of the draft. I can give you that now, but I can get you -- I know there is going to be another meeting on Thursday, I can get you a copy of the revised thing. They did some language changes in it.

ASSEMBLYMAN IMPREVEDUTO: I'd appreciate that if you could get that to us now.

DR. ZLOTNICK: Yes.

Again, as family docs, you know, we really pride ourselves with continuity. We think we have a very strong ethical duty to provide compassionate, quality, and safe care to our patients. And as much as -- you know, we are in support of everything else. I mean, that one little proviso is going to cause too many problems. If we could just soften up the language on that, we'd probably be in full support.

ASSEMBLYMAN IMPREVEDUTO: Are you coming on Thursday?

DR. ZLOTNICK: Somebody from our program will be there.

ASSEMBLYMAN IMPREVEDUTO: Would you come with some language?

DR. ZLOTNICK: I think we probably could do that, sir.

ASSEMBLYMAN IMPREVEDUTO: I'd like to hear it.

Eric.

ASSEMBLYMAN MUNOZ: Through the Chair.

Dr. Zlotnick, you shock me. I mean, I would think that the New Jersey Academy of Family Physicians would wholeheartedly support the bill. So, you're actually are concerned about the 24-hour language?

DR. ZLOTNICK: Yes.

ASSEMBLYMAN MUNOZ: Okay.

DR. ZLOTNICK: That's the only point in the whole bill that we have any concern. Seriously, that is the only point we have any concern about.

ASSEMBLYMAN MUNOZ: But as you recall, there have been several testifiers, some not in the room anymore, where there were pros and cons of that whole thing.

DR. ZLOTNICK: Yes.

ASSEMBLYMAN MUNOZ: It's interesting to find that, you know, nonsurgeons -- here you are, family practitioners, general practitioners that would be concerned about that. That's of interest.

DR. ZLOTNICK: Yes. It's the ability to follow somebody. Again, I know, I hear this from my own residents. They admit somebody during the night, they want to know what happened to them during the day. It's that sense of responsibility. This is my patient I admitted. I want to know what happens to him.

ASSEMBLYMAN IMPREVEDUTO: If I could just jump in. What happens if you admit that person and in an hour later another person and three hours later another person, you never go home?

DR. ZLOTNICK: Well, no. Obviously, you're going to have to do some cutoff. You have to have some sleep. Again, most of our residents are getting some sleep. We have some strict guidelines in terms of making sure residents are not overworked during the night. In fact, there are limits.

ASSEMBLYMAN IMPREVEDUTO: Yes, but doesn't that violate that whole continuity of care concept? If I'm there and I admit this patient and then I admit another patient and a fourth patient and a fifth patient--

DR. ZLOTNICK: There are limits on the number of admissions they can do during the night, sir.

ASSEMBLYMAN IMPREVEDUTO: Well, my point comes to that.

DR. ZLOTNICK: Yes.

ASSEMBLYMAN IMPREVEDUTO: My point comes to that there's going to be a limit, so why don't we create that limit?

DR. ZLOTNICK: Yes.

ASSEMBLYMAN IMPREVEDUTO: And if 24 hours is the creation of that limit, it's kind of like saying, we're going to have the cutoff for school. When your kid turns five years old by -- September 30 is going to be the cutoff day.

DR. ZLOTNICK: Yes.

ASSEMBLYMAN IMPREVEDUTO: Well, the mother says, "Well, my son can't turn five until October 1." We had to have a cutoff. The cutoff is September 30.

It would seem to me that even with the continuity concept, we need to have a cutoff, so we've created the cutoff at 24.

DR. ZLOTNICK: We were tossing around like 30, 34 hours as a more reasonable cutoff. We really didn't come up with a specific number at that point.

ASSEMBLYMAN IMPREVEDUTO: Okay. If they could come with some kind of reasoning as to why 30 or 34 instead of 24, I would--

DR. ZLOTNICK: It's the ability to stay, at least, through part of the day to see what happens with patients you admitted during the night and the ability to be able to attend some educational conferences during the day. That was the reason.

ASSEMBLYMAN IMPREVEDUTO: Let me ask you this. Would you be opposed, as far as educational conference -- and I know I spoke to some people about that and I know as -- this residency is, in fact, is an educational process?

DR. ZLOTNICK: Yes.

ASSEMBLYMAN IMPREVEDUTO: These are doctors-in-training. Would it make more sense that any of these educational lectures that are taking place be videotaped, so that that doctor, who might miss that because he was in surgery at that point in time, could take that videotape and watch it at another point in time?

DR. ZLOTNICK: Some places have the capability to do that, some programs do not. I can't speak for every--

ASSEMBLYMAN IMPREVEDUTO: I have a hard time believing that most hospitals don't have a videotape machine or, you know, a tape recorder.

DR. ZLOTNICK: I can't speak for every single program. We've tried -- our new order term of (indiscernible), we have the capability of doing

that quite well. I know some programs are going to be walking around with a little video camera and the quality is so bad, you can't see the slides they're presenting.

For some of the residents that do leave, you know, we make sure everybody gets a copy of a handout of the lecture. So, if somebody had to miss a lecture, they do, at least, get a copy of the handout, and they can refer to that lecture. And for the most part, most of our speakers are at least somewhat nearby, that you can get a hold of them. We do have outside speakers, and a lot of them leave their names and addresses with me, I can get a hold of them if they have any questions that they weren't able to ask that day.

ASSEMBLYMAN IMPREVEDUTO: Any questions?

ASSEMBLYMAN MUNOZ: Just one comment and, again, back to what I was saying a little while ago. Remember, we're talking about educating doctors and here you are saying that for a doctor's education, if I was a family practice resident--

DR. ZLOTNICK: Yes, sir.

ASSEMBLYMAN MUNOZ: --I might take, you know, offence or not like the fact that someone, some lawmaker like me, passes a law so that in 24 hours, I'm taking care of someone and learning and ethically want to be there, I'm told I have to leave the hospital, leave the environment. And we have heard that a little bit. That is one of the areas, I think, in the bill that I'll call gray, because I think you're going to hear both sides of, you know, the pros and cons of that.

And, you know, I gave an example of a person I was taking care of the other night, and I think the residents probably did stay for a couple hours over 24 hours. If they we're told, "You must leave" -- I mean, from the

educational side, I think they wanted -- besides the fact they were saving a life. So, you know, it's an interesting comment.

DR. ZLOTNICK: See that's where I'm coming from on that. You know, most of our residents express that they want to stay to, at least, see what's going on with that point of view.

It's not that, you know, we want to keep them working or make them continue forcing the 36, 40 hours, which we think, obviously, is ridiculous. Again, I myself don't want to be at the other end of that doctor, you know, somebody's overly fatigued. But, you know, part of things that we built into our program already -- and, again, we have to answer to our RRC Commission -- is the fact that residents cannot be overworked, they have to have adequate supervision, they have to have adequate backup. If there is a problem going on where residents are suddenly getting more and more admissions and they're suddenly, you know -- it exceeds their ability to handle it, there has to be a mechanism in place in all programs for someone else to come in and help these people. And if a resident is obviously appearing overly fatigued the next day after having some sort of night like that, they go home.

ASSEMBLYMAN IMPREVEDUTO: Okay.

Any other questions? (no response)

Thank you, Doctor.

DR. ZLOTNICK: Thank you.

ASSEMBLYMAN IMPREVEDUTO: We have a group of folks that have asked to be called together and that's Eric Scherzer, Associate Director of CIR/SEIU; Dr. Michael Thornton; Dr. David Rosenthal; and Dr. Shirley Jakubec. If you would all kindly come down and share the mike in some way, shape, or form.

ERIC SCHERZER: I just want to start off. CIR is the Committee of Interns and Residents. We're the largest resident union in the country.

ASSEMBLYMAN IMPREVEDUTO: Would you identify yourself, please?

MR. SCHERZER: Sure. Eric Scherzer, sorry.

ASSEMBLYMAN IMPREVEDUTO: Okay.

MR. SCHERZER: We represent 11,000 physicians including the physicians at UMDNJ, Jersey City Medical Center, Bergen Regional Medical Center, Saint Mary's -- 20 hospitals all over the State UMDNJ residents rotate through -- and Saint Michael's.

I'm going to limit my comments now because there are residents who have been waiting a long time, and they'd like to speak. Many of the residents who were here before already had to leave, so I'm going to give them the mike.

ASSEMBLYMAN IMPREVEDUTO: Please identify yourselves for the record.

DAVID ROSENTHAL, M.D.: I'm David Rosenthal. I'm a second year, PGY-2, in internal medicine at Saint Michael's Medical Center.

I'd like to speak on a few comments, and I'd like give forth a few ideas from the medical literature that have come up. I'd like to bring forth some vignettes that I've seen during my experience as a medical student and as a resident. And I'd also like to bring forth some other ideas and concepts that I think are very important in this legislation.

The first thing I think I want to stress is that patient care is compromised by long working hours. And I think this is something that we've seen again and again from both sides of this issue. I think that's a generally

fairly well understood concept. There was one example towards the end of a 24-hour-plus call day that I did when I was working with my intern, and we were admitting a patient to the hospital. We sat down to interview the patient in the patient's room, and the patient presented with chest pain. We were asking the patient about their chest pain, to describe their chest pain, and to find out if the chest pain was more related, based on our physical examination, due to a heart problem or to some other difficulty that could present with chest pain.

In the middle of our questions, my intern had asked the patient a question, and the patient responded, and then the patient was waiting for my intern to ask the next question, but there was a sudden silence. We took a look over at my intern, and my intern was sitting on the chair where he sat down to interview the patient, and my intern was fast asleep. His hand was on the admission paperwork, as he was doing the admission work, I was awake there, and the patient was waiting for the next question from the intern. I woke the intern up. We completed the rest of the interview. We were able to complete the admission paperwork, and we were able to, you know, finish the admission. No harm directly came to the patient based on this one experience, but is this the kind of care that we want to be providing to our patients?

A greater concern was the next morning, when the patient had -- when the intern who I've been working with was up the entire night. And they were trying to make medical decisions for the patients that we admitted to the hospital, and he was completely exhausted at 4:00 a.m. when we're trying to admit the patient, let alone when we're trying to make medical decisions for the patients we admitted the next day as he went into the 25th, 26th, 27th, 28th, 30th, 31st, 32nd hour before he was able to go home.

So these are the kinds of real life incidents and real life problems that come up. The intern, at that point, actually made a comment to me that he doesn't think that he was able to make the best medical decisions for the patient at that time, as he would have been able to make had his mind been clearer.

Earlier in my training, during my medical school education, I had an experience that was quite memorable in my mind. I was doing an OB/GYN rotation, and I was working in a hospital. We had delivered several healthy babies through the course of the night. The babies have been doing well, and we had had a number of regular deliveries, and then we had an emergency 4:00 a.m. C-section. We had been asleep about 3:30, and then things started not going so well so we're awoken at 4:00, and we went to go see the patient, and we needed to do an emergency cesarian section.

So the OB/GYN resident that I was working with was able to put on her scrubs -- she was wearing scrubs already, she was able to scrub in the operating room, put on her gown, and she was ready for the patient to be rolled in the room. As she was doing that, she was able to sit down on a stool before the patient came in. And while she was scrubbed, with her complete surgical attire on, she fell asleep before the patient arrived in the room. Then, the patient came into the room, was put on a stretcher, the attending physician came in, the resident woke up, we were able to take care of the patient. We had an uneventful cesarian section with a healthy baby that was delivered afterwards.

But that was the kind of fatigue that resident was experiencing at that point, and then that resident needed to go and do clinic where she was going to see -- I don't know how many patients in an OB/GYN clinic -- the

next morning, and the next afternoon, until 4:00, when her clinic was done, and she was doing Pap smears and doing other exams on other patients. I would not have wanted to be the woman that was being examined by this resident so much after she had been up all night.

There was a paper published in the journal *Nature*, in 1997, from a sleep center at the University of Australia. It attempted to equate the effects of cognitive/psychomotor impairment induced by sleep deprivation based on comparing that of sleep deprivation to the effects of alcohol. And we heard a quote from someone from a patient's advocate group that talked about this study also briefly. But the study basically showed that moderate levels of fatigue, which they said 24 hours of not sleeping, produced higher levels of impairment than the prescribed level of alcohol intoxication, which is a 0.1 percent alcohol level, which is the level in which it's illegal to drive in the State of New Jersey. So, this is one study, and there are many more that other things that are being expressed, but this is one issue that came up.

I know that as a resident, I'm in this program largely so I can learn to become a better physician. And one thing that's important to me is that I continue to have academic time where I can learn from conferences, learn from lectures, as well as learning from my patients. And one way that we do that is through rounds with our attending physician. But after I was working all day, all night, and then I was rounding with my attending physician at 5:00 the night after I had been up all night, the amount of knowledge that I can gain from these rounds with my attending physician is extremely limited. I had very little sleep during the course of the night. I'm there in presence, and I'm able to interact in the rounds, but how much am I able to truly absorb, remember, recall, and to use towards my medical education in a beneficial way

after being up all night? I think that my abilities are limited significantly at that point.

Residents are a danger to themselves and the public when they're sleep deprived. We were talking about this issue with a number of my colleagues over some recent renegotiations -- actually, we did at St. Michael's -- and one of the issues that came up was resident work hours. And there were a lot of stories that were being able to be told around the room. Many residents in the room had dozed off while they were driving home. Several of them had said they had to pull off to the side of the road several times on the way home because they couldn't keep their eyes open on their drive home from work, and they felt that that was unsafe. Thankfully, only a couple of people have had small fender benders. No one has been seriously hurt. No one has seriously hurt anyone else. But these dangers that we present when we're on the roads after being on-call, we all do not have access to public transportation after being on-call. We put ourselves and the public of New Jersey at significant risk due to motor vehicle accidents.

There was a study done at Wayne State University that was published in the year 2000 that showed a survey of 697 emergency room residents nationwide. That study came out saying that emergency room residents are 6.7 times more likely to have a motor vehicle crash due to falling asleep at the wheel than before they started residency, based on surveys from emergency room residents.

I'm pleased to hear about the recent changes from the resident also from CIR, here at UMDNJ and the changes they've made in their medicine program to include a night float system. For everyone that's not quite sure what a night float system is, what that means is that you have the ability for

residents to work all day long, and then it comes a certain time at night, say 10:00 at night, were the residents that are on-call are able to go home, and a separate group of residents are able to come in during the course of the night and to take care of the patients from 10:00 at night until 7:00 a.m.. And then when the regular group of residents that are there come back, then they take care of the regular patients. Then any medical problems or admissions that arise during the night from 10:00, for example, to 7:00 a.m. are handled by this night call group. And this group then turns over patients to their daytime teams basically.

What this allows is, as UMDNJ is doing, is it allows a group of residents to come in every night and take care of patients every night so they can have a semi-consistent schedule. So one month out of the year or two months out of the year, they come in every night only, and they don't work during the day. Then the other residents, they work all day long, and some of the times they work until 10:00 at night, but then they're able to go home, get a good night sleep, come back the next morning, and then they don't have any problems with the 24-hour limitation because everyone is working less than 24 hours. Everyone is able to see patients. The issue that comes up is continuity of care disturbed by this type of admission process.

ASSEMBLYMAN IMPREVEDUTO: What about what we've heard that you want to see what happened?

DR. ROSENTHAL: With what? I'm sorry.

ASSEMBLYMAN IMPREVEDUTO: You know, you did this surgery, you admitted this patient, and you really want to stick around to see what happens?

DR. ROSENTHAL: Exactly. And you know what -- I guess two weeks ago and again last night -- not last night, the last time I was on-call, which was Sunday -- I had it Saturday, thank you. There was a patient that I was admitting to--

ASSEMBLYMAN IMPREVEDUTO: How long have you been working? (laughter)

DR. ROSENTHAL: I'm actually on-call again tomorrow, which is very pleasant, which is why I actually can be here today.

But when I was on-call the last time, which was Saturday, I had a patient who became very ill upstairs on one of the medical floors. They were not doing very well at all. First, my intern was called, who evaluated the patient. Then I was called, I evaluated the patient. The patient did not look well at all, and so we ended up having to take a series of medical steps and transfer the patient to the intensive care unit where they could receive a higher level of care than what we can provide on a medical floor. Subsequently, the patient was intubated and had a breathing tube placed. And this type of care is very common in internal medicine. These are the kinds of decisions that we have to make, and that's why we're in the hospital to be able to make these kinds of decisions because patients are getting sick.

So this patient was now going from the floor, where I would have responsibility, where my intern would have responsibility to the intensive care unit where we did not have responsibility. There's a separate group of doctors and a separate group of residents and a separate group of attendings, in some cases, taking care of patients in the intensive care unit. That didn't keep me on Monday morning from going to the intensive care unit and seeing how my patient was doing. That didn't keep me from looking in, right before I left, on

Sunday morning, to see how my patient had done through the course of the night. And that didn't keep me from being able to talk to the family of my patient, who I had to talk to on the phone to tell them that she wasn't doing well, when they arrived in the intensive care unit, while I was still on-call that evening.

So, yes, I am able to take care of my patients and maintain some sort of continuity of care and satisfy my own intellectual curiosity about how patients are doing, but that's without having the requirement of me being on-call to an exorbitant number of hours where my ability to take care of patients is significantly limited. So that's, in this case, how that would have been able to have been handled.

There are certainly special situations and certain instances where it becomes difficult, you know, when something is going on. If you're doing operations in an intensive care unit, in a surgical intensive care unit, then maybe having someone who had been in the major operation would be very beneficial, but they're also able to tell the other doctors what goes on in that performance. And I'm sure Dr. Munoz was able to sign out to the attending physician who was taking care of the patient while he was having to be elsewhere -- what happened during the operation and how things were able to be done so that he could, successfully, transfer care of that patient to another physician who could provide adequate and good care for that patient in a responsible way.

ASSEMBLYMAN IMPREVEDUTO: You know, what I'd like to do, and I think we all have some questions, but I'd like to hear from the other two. Squeeze them down and if all three just stay there, we're going to throw some questions at you, I suspect.

SHIRLEY JAKUBEC, M.D.: Hi. Good afternoon.

My name is Shirley Jakubec. I'm a third year resident in internal medicine.

ASSEMBLYMAN IMPREVEDUTO: Shirley, could you just move that microphone down a little bit?

DR. JAKUBEC: Down? Okay.

ASSEMBLYMAN IMPREVEDUTO: There you go.

DR. JAKUBEC: A third year resident in internal medicine at St. Michael's Medical Center, which is just down the road from here.

The angle that I would like to take to address this issue is just a matter of looking at the wording of the Legislature itself and to recommend possible amendments to it to make it stronger and make it more responsible, perhaps, as Dr. Bell was talking about earlier in our session.

The first point, we've talked a lot about the hours, and I just want to make a point on Section 1, when it talks about the hours not exceeding -- let me just get the exact wording so I'm not misquoting, "that the medical resident shall not exceed an average of 80 hours per week over a four year -- four week period." We would like the CIR, who I'm part of, is the Committee of Interns and Residents -- the three of us, we're delegates of that organization. It's a national organization, CIR.

As the CIR, we've met, and we would recommend a few amendments to the wording itself. And at this point, about the hours, 80 hours, over an average period of four weeks, that issue, to amend it to 80 hours per week. Now someone had addressed the idea of it being rigid, this point. This -- we're talking about the -- the key wording is that this is a scheduled work period. That it would be limited to 80 hours per week and not averaged

over a four week period. We know that from the experiences in New York that the average in certain programs, and as we heard, one of the residents speak of the urology residents or some of the OB residents, they'll still topple up many on-call hours in a two-week period so that they would have time for a vacation or weekends off. They punish themselves, as someone put it, so that they could get these hours and have them averaged, at least, to 80 hours. But somehow there needs to be this wording that it could be more responsible to have it as an 80 hour work period per week.

And to address the issue, I just want to say, St. Michael's -- I don't -- we don't know experientially what a night float system is. We do not have this in place at our hospital, and many programs do not have that in place. It does address the issue, as David already pointed out. It does help the issue of the hours, but certain programs still need, would need, the start of Legislature about the hours put in. It would be very beneficial to the residents because we don't have these kinds of things that are built into our system.

The issue about the 24-hour week, I don't see a problem in this because as the wording is stated, "a medical resident shall not be scheduled for more than 24 consecutive hours in either patient care, educational sessions." The key word is the responsibility of being scheduled. You are the responsible resident for that 24-hour period. There's no mention that there's no point of your enthusiasm to see the patient afterwards. Many times I've had cases as well -- I had an ectopic pregnancy that I admitted through the ER one night, and I definitely wanted to see what happened to the case. She had a full abdomen of blood, and it was irrigated, it was taken out, and she was well the next day. So, that was a beautiful case that I did want to see what happened.

But the key word is responsible. I thought that was so great Dr.

Bell mentioned that. So, I don't see any problem with the 24-hour period. The key word is a responsible, scheduled period. And that's been already addressed in this issue so I think it's very good wording there.

The other point about the hours, and the last point about hours -- I'll stop about hours -- is that we would recommend that in Section 5 that it read, "a resident shall have a nonworking period of, at least, 10 hours between other shifts." And this provision, it would be necessary so that residents would actually have time, as we're hearing, to go home and get rest. Some residents have stayed in the hospital, actually -- I know at St. Michael's -- because they were fearful of driving home. So, they've stayed overnight and then were wrinkled the next morning and stayed overnight because they were afraid to drive home in the state that they were in. So, that's an example of that. So, having an adequate nonworking period hours would be great between shifts and that should be--

ASSEMBLYMAN IMPREVEDUTO: Were they charged for the room?

DR. JAKUBEC: Sorry?

ASSEMBLYMAN IMPREVEDUTO: Were they charged for the room? (laughter)

DR. JAKUBEC: No, they find a place where they could find adequate rest.

I have two more points just to make here -- is the issues about the penalties and enforcement of the bill. People ask, "Well, how can this be regulated?" And in New York, we know that, as Dr. Bell mentioned, even though the law was there, it had not been enforced until it became a bit more strict in its wording and in its cost.

And cost was brought up today. It is a matter of a cost. And as some of you will know, the Health Care Reform Act, 2000 in New York, the penalties were actually increased -- I mean, New York State from 2500 to 6000 per day that the hospital would be in violation of these sorts of bill issues.

And in addition, we would ask that a provision be made for a corrective plan to be put in place perhaps for a 30-day period. That if there was a violation made, there would be some sort of restorative plan, not just a penalty given. And then, what happens from that point? So, it would be good to have some wording of a corrective plan, perhaps, within 30 days, to be submitted to the Department of Health, for instance.

The last point I would say is, it was mentioned, I think, by AMSA -- I don't see the gentleman here anywhere -- echo one of his points, he just briefly mentioned it, about a provision made for, possibly, an annual anonymous survey that could be given, perhaps, within the medical community, amongst residents, perhaps, or even attendings, who would know certain things that are not being done right. But an anonymous annual survey could be made to determine whether there has been any compliance made for the issues that I bring forth.

And one very important matter I would bring to the forefront -- I think, it's an important issue. In our forum, we brought a -- this is a medical and a political sort of forum here, but it really hasn't touched the issue of the public yet. For instance, I'll just say that the public really is not aware of the issue, I would say, of resident hours. For instance, there have been many times when I've been on the floor, I've been up all night, and I admit a patient in the early morning hours, come back the next morning or early afternoon the next

day to care for the patient in whatever state, and the patient would assume that I've gone home. They say, "Oh, so did you have a good night sleep?"

And I say, "No, I've been here all day. I've been here all night."

"Really, they still do that?"

I've been so amazed how many people in the public have said that. There really is not a public awareness of the issues. So this is a great time to bring this issue up and that people would know more about it. So, at this point I'll close, and I'll just thank the Assemblymen and the Committee for bringing these issues up. And we strongly would like to see change made.

Thanks.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

MICHAEL THORNTON, M.D.: Good afternoon. I'll be brief.

My name is Michael Thornton, a second year resident over at St. Mike's working with Shirley and David.

I come from the military, and this is my second career. I have 12 years in the service, 11 years in being with Special Warfare, the SEAL Team. I've done the Spec Ops overseas --

ASSEMBLYMAN IMPREVEDUTO: You guys might want to have a conversation over there. (laughter)

I fought the Battle of the Turnpike during the '60s. And there were no Viet Cong this side of Edison. (laughter)

DR. THORNTON: I've done my time in Spec Ops. I've done my deployments. I've done my in-country experience. We talk about the military. The military does not train this way. I've done my job in training platoons that go overseas. In addition to special boats, we go into countries which we still do not talk about.

I support the bill. ACGME -- it's laid out. What I'm looking for, not to beat it -- flog it at horses -- accountability. The system's in place. Let's hold it accountable, and let's stick to it.

I can go on with anecdotes. I'll just give one case. Two months, back-to-back, Q3 call. I arrive between 6:30 and 7:00, signing out the next day at 5:00 p.m., responsible for all the patients with no sleep. It's common. That's what happened to me.

I don't have a problem about getting into an accident driving home. I take mass transit. I walk to the train station. I have a sign around my neck, "Wake me in such and such a town." I get off and walk home. (laughter) So that's my--

No questions -- I guess we can go ahead and answer questions.

ASSEMBLYMAN IMPREVEDUTO: Yes, I would ask the three of you to stay up so the panel can ask whatever.

ASSEMBLYMAN MUNOZ: Just a--

ASSEMBLYMAN IMPREVEDUTO: My cosponsor, please.

ASSEMBLYMAN MUNOZ: Thank you, Mr. Chair.

Through the Chair, you know, one point you made about the 80 hours, changing the language of the bill, which just says 80 hours per week. Now, you know, we have 2600 residents in New Jersey and 50 different types of programs, probably at 40, 50 hospitals, you know, some places like this. Institutions have hundreds, other places may have 5 or 10.

When you get into trying to do that -- in other words, you know, one week you're coming off of an IC rotation, and then you're shifting to something else. Even if I gave you all of the incentives in the world, said you were a wonderful person, doing that creates some real headaches. So, I mean,

I think there is a practical side where I understand what you're saying. On the other hand, if you ask the people that run the programs all over the State, and every different type of program, not just medicine, and you look at OB and psychiatry, you do get into some logistic kinds of issues.

DR. JAKUBEC: Right. I'd like to make a comment.

I've also come from a surgical background before this, and that was in New York before this, and so, I've seen, sort of, both sides of the issue. In medicine now, I've found that the hours really did not change that much, although they were more intense in surgery, they're a little less intense in medicine. But it's interesting that the ACGME guidelines themselves also say the wording of the 80 hours, and they particularly word it as direct patient care duties. Now these 80 hours, that's a very clever way to put it because they're so many times during lecture periods that we've been paged for things that could have waited, and it interrupts our educational time. And I was actually, indeed, told by an attending that these 80 hours do not count to your educational hours.

If you understand that, that's a very sly way to say it that the 80 hours are patient care duty hours. So, in addition to our lectures, which are 3 hours a day, at least; perhaps, maybe an attending round, which would add another 1.5 hours; perhaps, that would -- maybe 4 hours, maybe even 5, I'm not sure of educational time per day. Those are not counted per day to the patient care duty hours. So, it's very interesting. These are the guidelines of our ACGME. This is in internal medicine. I'm not sure what it is in surgery now, but it's a very clever way in wording things. So, we have to be careful how this is worded.

DR. ROSENTHAL: And yet, if there's a problem that comes up while we're sitting in one of these hours of lecture, our pagers still goes off, we still need to address the problem on the floor if the patient is sick. We're the initial responsible party. Attending physicians, of course, respond as well. But we're sitting there, in these lecture hours, when, you know, we also are taking care of patients during that time also.

DR. THORNTON: I just want to add one question. Is it the need to the hospital or the need to the education?

ASSEMBLYMAN MUNOZ: Well, you know, one of the things -- look, in the last thirty years, when I was a medical student, I was a medical student in New York, and then, of course, a resident in Yale, there were probably things that happened--

ASSEMBLYMAN IMPREVEDUTO: You're no longer a doctor, by the way. They've taken that away. (laughter)

ASSEMBLYMAN MUNOZ: That's right. I'm a highly paid State-elected official.

But there were things, no question, I saw happen that wouldn't happen in the year 2002. Now, not that medicine is perfect -- what we're trying to do is, you know, optimize, and that's what this hearing is about, the best possible patient care in the milieu of resident training. And, you know, we're obviously a receptive audience. On the other hand, there are some areas, we're hearing pro and cons too in this. I'd love to get some surgeons up there too and see what they have to say about this.

ASSEMBLYMAN IMPREVEDUTO: They're all working.

DR. ROSENTHAL: It's difficult to --

ASSEMBLYMAN MUNOZ: Yes.

ASSEMBLYMAN IMPREVEDUTO: They're all working.
(laughing)

DR. ROSENTHAL: I think it's a factual point that it's probably difficult to get surgeons to come up here, surgical residents to come up here and speak on this issue.

ASSEMBLYMAN AHEARN: They never sleep if they had the time? (laughter)

DR. JAKUBEC: I think, you know, it's a cultural issue as well.

DR. ROSENTHAL: And I think there's a pressure among, you know, among the residents themselves between possible concerns about what would be going on with the program. I think there's an issue. And I think that it's poignant there are not surgeons here.

I think one thing that's also interesting is, you know, other professions have limits on the number of work hours. People that are -- you're driving trucks or are going to be flying planes or going to be doing other things like this, all of these professions have reasonable work limits on them. Now, who's going to say that the truck driver that drives one extra hour is going to be at a risk when they didn't at some point? But at some point you need to put limits on the number of hours the truck driver or the airline pilot is able to fly or to drive or whatever. And it's the same issue that we're dealing with here. I mean, we're setting arbitrary limits on a nonarbitrary matter. But you need to set those limits so that you can make sure you don't step so far beyond those limits that other people, that those workers and the other people that are affected by those workers are not adversely affected.

ASSEMBLYMAN IMPREVEDUTO: Matthew.

ASSEMBLYMAN AHEARN: No, I'm fine.

ASSEMBLYMAN IMPREVEDUTO: I have a question that you may or may not want to answer. Are you all graduates of here? That's not the question, just a curiosity.

DR. JAKUBEC: No, we're all at St. Mike's.

ASSEMBLYMAN IMPREVEDUTO: Are you all graduates of here, at UMDNJ?

DR. ROSENTHAL: No, we're from different medical schools. All of us.

ASSEMBLYMAN IMPREVEDUTO: All different.

You are from where?

DR. ROSENTHAL: I graduated from the University of Health Science, College of Osteopathic Medicine in Kansas City.

DR. JAKUBEC: I'm a foreign graduate from St. George's University in Grenada.

ASSEMBLYMAN AHEARN: I was there.

ASSEMBLYMAN IMPREVEDUTO: I suspect that you were.
(laughter)

DR. THORNTON: Likewise Shirley, I went to St. George's after the service.

ASSEMBLYMAN IMPREVEDUTO: Do you feel, well, since you're not from here maybe you might want to answer this question. Do you think there would -- and I don't believe that this University would ever think about this -- but I need to ask the question. Do you feel that, in any point in time, that a resident who would step forward and say, "Hey, wait a minute. I've worked too much. I'm not doing this anymore," would be in jeopardy of losing their internship if you could fail such a thing? I don't know if you can

or you can't, but whatever the action is that might be taken, that might be negative to you as a future medical doctor or as a--

DR. THORNTON: From my observation--

DR. JAKUBEC: I'd say--

DR. THORNTON: Oh, go ahead.

DR. JAKUBEC: Go ahead. You go ahead.

DR. THORNTON: Okay.

From my observations--

ASSEMBLYMAN IMPREVEDUTO: Please step closer because this is being taped.

DR. THORNTON: Sorry.

From my observations, yes and no. I think, with respect to renewal of a contract, I don't have that information. However, with respect to the working environment over the next couple of days and weeks, yes, there will be repercussions.

ASSEMBLYMAN IMPREVEDUTO: You say that fairly confidently?

DR. THORNTON: Yes, sir.

DR. JAKUBEC: There also are repercussions, perhaps, in looking ahead. Also if you, perhaps, would like to do any fellowship. A fellowship is a speciality after the main residency. So, being sort of like the whistle-blower might be detrimental to your acceleration upwards to more training.

ASSEMBLYMAN IMPREVEDUTO: Dave, is there a problem for you?

DR. ROSENTHAL: I think we're in agreement.

MR. SCHERZER: Can I respond to that question?

ASSEMBLYMAN IMPREVEDUTO: Wait a minute, let me talk to them first.

MR. SCHERZER: Okay.

ASSEMBLYMAN IMPREVEDUTO: Do you see the need for something in this legislation that would protect a resident who said, "Hey, wait a minute. They're really violating this." And that was what I think you meant. Okay.

DR. JAKUBEC: That's why we mentioned the annual anonymous survey that could talk about compliance.

ASSEMBLYMAN IMPREVEDUTO: See, the problem I have with an anonymous survey is somebody gets, in the vernacular, pissed at the hospital for some reason.

DR. JAKUBEC: Yes.

DR. ROSENTHAL: Yes.

DR. JAKUBEC: Yes, that's true.

ASSEMBLYMAN IMPREVEDUTO: And says, "Yes, I'll get you." And they call in whomever it is that we call in to review this, and it's found that, you know, to be not true. I mean, anonymous things are nice, but I would rather have somebody's name on it and then protect them.

DR. ROSENTHAL: That's difficult.

ASSEMBLYMAN IMPREVEDUTO: Because when somebody puts their name to something, certainly, they're not going to lie about it or they're not going to put forward a false statement.

DR. THORNTON: Sir, if we were in the service, I would say, yes. That would work because of other factors of integrity, and there are many different -- there is a realm, which I don't want to get into -- but being in a

civilian environment, I would say things are different. I would have to say once your name goes on that piece of paper, you are held accountable. And you could go ahead and try to plead your case, whether right or wrong. Short-term, you'll be indirectly or directly threatened with your chance for a chief residency, your fellowship, job positions. It's a large community.

I'm interviewing right now for my fellowships and each program I go to, even though they're on different ends of the Coast, they're still intertwined because you have graduates going from one program to the next. And I've been finding out that each program has been talking about my positions. So, even globally, it's a big world, but it's very small.

ASSEMBLYMAN IMPREVEDUTO: So you don't want to be labeled as a troublemaker?

DR. THORNTON: I already am. (laughter)

DR. JAKUBEC: Can I make one quick comment? The anonymity. That's the word I want, right.

DR. ROSENTHAL: Anonymity.

DR. JAKUBEC: That's the word I want. Right.

I think that would be all right because I think you'd have very few cases where what you brought up would occur because, the truth be known, upon investigation, I think if there any deficiencies, you would find them. And you would find them to be false or true. I don't think there would be a problem with that anonymous sort of avenue.

ASSEMBLYMAN IMPREVEDUTO: Folks--

ASSEMBLYMAN MUNOZ: Actually, I was just commenting about the Chairman's question about repercussions. You know, when I was at Yale, a program that was just cited 30 years later, we used to say, "No one likes

a complainer,” you know. And that saying among the residents, there was some merit. So, I mean, in a perfect world, what you do may have no impact, but in an imperfect world we live in, I can see how, you know, things might work. So, you know, just one of the issues we have to be cognizant of.

ASSEMBLYMAN IMPREVEDUTO: If you’re done and -- Matt.

ASSEMBLYMAN AHEARN: Yes, I’m done. Fine.

ASSEMBLYMAN IMPREVEDUTO: Okay.

DR. JAKUBEC: Thanks.

ASSEMBLYMAN IMPREVEDUTO: I want to thank you. And I’ll tell you all three are going to make wonderful physicians some day and very shortly I’m sure.

DR. THORNTON: Thanks.

ASSEMBLYMAN IMPREVEDUTO: Well, you are, actually. I’m still getting confused with residents and interns and -- well, you’re wearing a stethoscope so you must be a doctor. (laughter)

MR. SCHERZER: Can I say a word or two to respond to some of your questions?

ASSEMBLYMAN IMPREVEDUTO: Absolutely. Please be brief.

MR. SCHERZER: I believe, CIR had asked for an inclusion in this Act, a whistle-blower protection. There is the New Jersey Conscientious Employees Protection Act--

ASSEMBLYMAN IMPREVEDUTO: Larry just whispered that to me while they were talking.

MR. SCHERZER: Once we make this a law, right, in New Jersey, we’ll protect doctors like that, but I can tell you that hundreds -- dozens of our members in New Jersey -- and we represent 60 percent of the physicians in

New Jersey -- interns and residents come forward to us out of some of the fears that the doctors were referring to, to ask us to sponsor and push and advocate for, which we have for 40 years, legislation in this arena, because this is a way where we can get some of the stuff done.

ASSEMBLYMAN IMPREVEDUTO: And for the record, you did not come to me to do this bill.

MR. SCHERZER: Absolutely.

We had sponsored legislation in the past and, independently, you brought forward this legislation, which we certainly salute you for -- you and Assemblyman Munoz. Dr. Munoz, excuse me.

ASSEMBLYMAN IMPREVEDUTO: No, no, right now he's an Assemblyman. He's not Doctor.

MR. SCHERZER: Okay. At this hour, he's Assemblyman.

One other point that I just wanted to make in terms of issues that were brought up before. If we are concerned about education time, then one of the provisions that we should put into this bill is protected education time because, as the residents were talking about before, in many, many, many of our programs, residents sitting in educational programs are paged out because they have educational responsibilities. They have patient care responsibilities while they're being educated. And if we're serious about looking to protect their education, we should protect it in this bill and having doctors turn off their pagers, give their pagers to other people while they're in educational programs to protect their education time, because that's almost as critical as their patient care responsibilities.

And finally, in commenting on the New York experience we, for many years, have worked in New York. We represent 5000 residents in New

York City. We've advocated for the bill regulations. I see Dr. Sears here, one of our former CIR Presidents from New York who could tell you about the experience in New York, having done a residency before the Bell Commission and then after the Bell Commission. There have been no cases of residents who've walked off the job because their 24 hours are up. There have been no cases of hospitals that have been cited for a resident working over 24 hours.

In fact, the enforcement agencies had said, just like the New Jersey State Troopers enforcing 55 hours speeding limits, "let's extend it to 82, 83, 84, 85 hours, average, before we fine hospitals." Those are the programs that have been cited. And unless we put a reasonable limit on it, 24 hours is a reasonable limit. In fact, most of the sleep researchers in the area, when you talk to them, will say, "After 16 hours, you're impaired."

Twenty-four hours is a reasonable limit. It's in many ACGME standards. On the other hand, it's not in many others. So we need to have State action, and we need to have State action now. And we salute you for bringing this forward.

And thank you very much.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

Before I call my next witness, is there anyone here in opposition that would like to speak? (no response)

No one here in opposition, okay.

Dr. Ceus.

FAIDHERB CEUS, M.D.: Good afternoon.

My name is Faidherb Ceus. I am a Chief of a psychiatry emergency room at Westchester Medical Center. I take some time today. It's very important for me to come here.

I'm not here on the name of the resident, but on the name of future patients. The issue is when you are sick, do you want a physician who was working for the last 16 hours? I want to talk about it because I was a resident in 1987. I have two specialities. My first speciality is, which is psychiatry -- I was an intern in '87. When I finished psychiatry, after the Bell Commission, I was, again, a resident in internal medicine in 1991. So, I know what that means -- working more than 24 hours.

Again, I'm not here on the name of the resident, but on our future patient. Believe me, whoever will be sick, you will go to the emergency room, you really don't want a physician who been working very hard for the last 16 hours. You don't want that.

I'm a patient advocate. I'll be always a patient advocate. They didn't explain it how staff physician would just leave there and go no place. But believe me, you sleep when you're tired. When you're tired, you sleep. You don't do it, you just sleep. It has happened to me. It has happened to me driving. I was a first year in 1987. You are tired, you worked 36 hours, you go home, and you have an accident. And look at the data, you would see the number of accidents occurred to a resident, intern going home. That was one of the reasons hospital try to get residents to live in the hospital.

I think the Libby Zion case teaches us a lot. That resident was tired, there was no supervision, and mistake was done. A mistake is done every day. We try to minimize it, but we know, we know. Look at the report two years ago. We know, a lot of mistakes were done because people were very tired.

Please, I would like that to be considered, because of my own testimony, as a resident -- and both times it was a pleasure to be a resident the

second time. You work from 7:00 in the morning, you go home at 10:30 -- at 10:00 because on that time there was intervention. There is a fund to have all the resident work at night, and then you don't lose track of your patient. Your curiosity to address the medicine, you will go back to them in the morning. You will want to know. And you will see patient -- a resident will volunteer only an hour or two just because of that commitment to do the best for the patient.

Again, I'm not here for the resident. I'm here for future patient. You don't want to go to emergency with chest pain at 3:00 in the morning and the physician seeing you been on-call since 8:00 a.m.. It's not fair. Please consider that bill.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

DR. CEUS: Thank you so much.

ASSEMBLYMAN IMPREVEDUTO: I'd like to call up Mark Levy, Executive Director of CIR.

MARK LEVY: I've been working for CIR almost for 19 years now. And I was there working with residents full-time before the Bell regulations, during the Bell regulations, when they were first passed, then for a number of years when they were passed but not really enforced, and for the last couple of years, they've started seriously enforcing them.

I just want to make, at this late time in the day, a couple of comments. First of all, to some degree, some of what we've heard today from the medical societies and the hospital associations is what a great American once said, "Déjà vu all over again."

In 1988 and '89, when the regulations were passed in New York, similar bills were introduced in Massachusetts and California, and the same

medical societies, and the same hospital associations came in and said, “No, no, no, don’t pass a regulation. We’ll police ourselves. We’ll start guidelines.” And, in fact, in Massachusetts, they even set up a committee. The committee, I think, met once.

If you look at the guidelines, the ACGME guidelines -- in fact, there was zero guidelines before ’88. They started introducing some guidelines afterwards. All of them were very mushy language, you know, “it is desirable, it’s recommended.” Nothing that’s really enforceable.

There wasn’t another state of professional self-examination until basically this past spring when the OSHA petition was introduced and when the legislation was brought up in Congress. And so, I think, what we see is another attempt to not have legislation so that, hopefully, people will stop looking at it, and it’ll go away.

So, I’m not moved by the industry and the professional standards. In fact, Dr. Goldstein made a number of misstatements here about the New York regulations. I think Eric Scherzer mentioned that there is not one citation in New York State for working 25 hours or working -- I forget the comments that he was making. It’s just not true.

The whole series of red herrings that for 15 years have been thrown out, whether it’s about moonlighting, whether it’s about continuity of care, whatever. These same arguments can be developed to say, “No, don’t do anything.” It is very easy to defend the status quo. And what you’re doing, and you have our respect for this, is to look to change the status quo.

I had the great privilege, in a certain sense, of not being a physician because you hear a lot of discussion about the culture of medicine. I think of myself, what in my union role is sort of an enforcement agency, but

really in another role I'm an anthropologist that every once and awhile gets dropped in to take a look at the culture that goes on. And just from today, a couple of examples I'd just like to bring up.

The doctor from family medicine talked about how he wants his residents at the noon lecture. Now, that's a strong commitment to education. However, I used to be a professor. I taught. I taught one session at noon, one session at 3:00, and another session later in the afternoon. When marvelous professors or doctors, whether it's in the university, a guest speaker, or in medicine, somebody's flown up, a specialist, to give a wonderful lecture, they give the lecture at noon, and then go out to dinner with the guys later. Right, there's a dinner, you know, faculty dinner. Why can't those lectures be given in several sessions during the day? Why can't they be videotaped? The whole culture of the day can be looked at and changed from that to--

Here's another example that came up today. Residents said my attending comes in at 4:00 or 5:00, and I do rounds with my attending at 4:00 or 5:00. What have they been doing for -- what have the residents been doing, and why do the attendings come in at 4:00 or 5:00? Why can't they come in earlier? What does it take to get them in earlier? And we've, through focus groups, developed some discussions with residents to start taking a look in detail at the resident day, to look at the elements that could be changed. The resident day can be changed without compromising either patient care or education if there's a reason to do it. And the sad thing is, there will only be a reason to do it when there is legislation to enforce it.

Now, in our experience, and the IPRO experience here by several of the hospital association speakers, have really mischaracterized a number of things. But what I hear from IPRO, which has just started out the last couple

of months when New York got serious about enforcing the regs, there really are three different categories of programs, and they've just started so that the data that you've heard about 50 percent noncompliance was on a small sample. That data was only of hospitals reported in the first go-round.

But there are really three categories of hospitals: one, is the other 50 percent or more that are actually complying because they support this, they have the motivation to comply, and they're complying.

There is another category, which is a big category in the middle with well-meaning, well-intentioned program directors and chairmen who would like to do better, but don't know how. They don't have the anthropologists coming in to take a look at their day and saying, "Here are some tricks how to do it." And one of the things that IPRO is doing, and we're trying to do, is to do studies of best practices. And we've put up some money to reward and to find out some of this information, so we can share this information. So, there's a large group that would like to do better, and it's not through a mathematical formula because 80 or 24 is a maximum. Right? So it could be less. We're really trying to get it less. And it's possible.

Then there's another small group, somebody called them cowboys, somebody called them renegades, you know -- what are they called rogue nations, rogue departments that say, "I don't care what the regs are, I'm going to just do what I'm going to do. Nobody can tell me." And so that's what you have speed limits for. That's what you have all sorts of other things for to basically say to the rogue departments, "No, you can't do it." To say to the ones in the middle, "Maybe you should try a little bit harder." And that's what we need regulations for.

The last thing that I just want to close with -- because I heard it from up here, and I was just shocked. I don't remember who said it. They said that you cannot follow the dots to prove that fatigue caused an error. Let me say something else. Errors mean errors. And what they forget to tell you or don't tell you is that there's another whole category called near misses. A near miss doesn't get recorded as an error. You know the doctor who is about to fall into the cavity that was described before. He caught himself before he fell into it. That's not an error. It didn't happen. That's a near miss.

But there are some people who say that you cannot connect the dots between fatigue, exhaustion, sleep deprivation, and the particular error. I think, like in the train industry and other industries, the burden of proof has to be put the other way. There's an expression called rule out. If common sense and the majority of data says that there is a likelihood that this could be a contributing factor, the burden is now shifted to the other side to say, "You have to rule out fatigue." It is common sense that if you're up 16, 18, 24, 36 hours, you can more likely make mistakes.

And what I hear from the industry is sort of like tobacco and asbestos and some others saying, "We still have to prove that tobacco and asbestos, you know, kills people." No, it's the other way around. We know what fatigue does, and I think that the industry needs to figure this out before the trial lawyers and everybody else says, "Hey, you knowingly, consciously had people work a certain number of hours. You scheduled them to do clinics after an on-call. You scheduled them to work all these hours and you did that despite all this research. What's your malpractice liability?" Right.

We are not trying to go to that area. We're trying to find ways to say to the profession, "You haven't acted responsibly as a profession in 20

years. Medicine has changed. Legislation should be the step that moves you to act responsibly.”

So, for all of those reasons and the reasons that you’ve heard, very honestly from the residents who work these hours, I support this legislation, and I thank you for your efforts. And I’m open to any questions.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

Questions? (no response)

Okay, thank you.

We have a few more folks, but let me ask you if -- I’m going to ask you if you have nothing different to say, you have nothing new to bring to the table, you know -- I think we’ve heard enough anecdotes. We just need you -- anybody that’s coming up to bring up something new.

Bernice Girard (*sic*).

B E R N A R D G I R A R D, R.N.: (speaking from audience)
Assemblyman, it’s Bernie.

ASSEMBLYMAN IMPREVEDUTO: Bernie, I’m sorry. It’s so late now, I’m--

Bernie, you left some papers.

MR. GIRARD: (speaking from audience) Okay.

You know what, Assemblyman, may I defer to a physician here who has to get back to her--

ASSEMBLYMAN IMPREVEDUTO: Absolutely. Sure. Certainly.

MR. GIRARD: (speaking from audience) Thank you.

R E G I N A A D A I R, M.D.: How are you all today?

ASSEMBLYMAN IMPREVEDUTO: Your suppose to wear it around your neck. (referring to stethoscope) (laughter)

DR. ADAIR: Good afternoon.

My name is Regina Adair. I'm a third year OB/GYN resident here, so I am a surgeon. I recognize that you all have been hearing--

ASSEMBLYMAN IMPREVEDUTO: One of your people, huh?

ASSEMBLYMAN MUNOZ: Better get her name spelled exactly correct for the record. (laughter)

DR. ADAIR: Pseudosurgeon, if you ask the general surgeons.

But I'm here as an advocate of this bill. As obstetricians, people don't have babies 9:00 to 5:00, so we're up at any time of the night. And, you know, for me it's sometimes difficult. You love what you do. OB is one of those fields where you have to love what you do to do this, but there are times when you just don't have the energy because you've been up all night.

And as a surgeon, we are in the abdomen after being up for 36 hours delivering the most perfect thing for every family: their first child, their first grandchild. And everybody expects it to come out without any problems. And me, as the physician, would definitely like for that to occur, but sometimes, you know, we're tired. You can't do your best when you're exhausted.

And I recognize, as a surgeon, that in the past, surgeons suck it up. You suck it up. In the old days, you were up for 24 hours. You did everything. You stayed up, you're with your patients, you did, you know, 40 C-sections, you did 50 ectopics in one night. Surgery is an institution. Slavery was an institution too, but it was wrong and it needed to change just as this does.

There is no reason that we are the only profession that's held accountable for everything, for someone's life. If we do something wrong,

lawyers are out. You'll see the advertisements on television, "And so, well, your baby has a scar on its forehead, you know. Call us, Brockman, Brockman, and Smitz." We are the only profession that's held accountable for every little minuscule thing. But there is no accountability for our work hours, for our tiredness, and that definitely needs to change.

I mean, there definitely needs to be something done that's just not legislation for the work hours to be decreased. There needs to be the coordination between legislation; between the RRC, which is the Residency Review Committee; between ACGME. You can't do this from one aspect. You have to have everybody coming together. Because you guys pass legislation that says, "Work hours are this way, work hours are that way," so then that requires the RRC and the ACGME to change stipulations. The ultimate goal for us is excellent training.

And I recognize, as an OB/GYN resident, in order to learn, you must have volume. So, what can we do so that we maintain the same amount of volume, the same amount of influx of good cases without the hours? We travel to four different hospitals. Four hospitals in order to get the same amount of cases that some of the residents who proceeded me only had to go to one hospital for. Because of the changes in medicine, we no longer can stay at one hospital to get the same operative experience. You can't just take someone to the operating room for a hysterectomy now because they have bleeding. It just doesn't occur.

So, therefore, there has to be a collaboration between all of the groups that control our residency training so that we can maximize our learning from a clinical standpoint, from an academic standpoint, and also allow for us to rest.

I'm done.

ASSEMBLYMAN IMPREVEDUTO: Regina, thank you.

Questions?

ASSEMBLYMAN MUNOZ: Through the Chair, actually, I have to compliment you coming forward for the Committee, especially as a surgeon in training.

DR. ADAIR: A pseudosurgeon.

ASSEMBLYMAN MUNOZ: You know, the first part of our law says that, you know, a resident would not have worked 80 hours per week over a four week period, on average. If you look at your last four weeks, do you think you're over the 80 hour--

DR. ADAIR: Without a doubt.

ASSEMBLYMAN MUNOZ: Okay.

DR. ADAIR: I mean, there's no way it could be done when we go to four hospitals with 28 residents. It can't happen.

ASSEMBLYMAN IMPREVEDUTO: You know, if I can just jump in a second.

ASSEMBLYMAN MUNOZ: Sure.

ASSEMBLYMAN IMPREVEDUTO: There was talk about continuity of care and unfortunately those folks are no longer here, I guess. Wally's here.

You know, I can remember with having our children there was a group of obstetricians. And we got to the hospital and Doctor X was on, but by the time my wife was ready to deliver, Doctor Y was there.

DR. ADAIR: Yes.

ASSEMBLYMAN IMPREVEDUTO: And these were not residents, this was-- These were the guys that were already out there doing their thing and, you know -- so, I guess I wonder where the continuity of care, in the sense it was defined here, happens after the residency is over?

You know, I should have asked that before. I didn't think of it, but, you know, the question of well, the patient -- you admitted the patient, you should be there, you know, until -- I don't see that happening even--

DR. ADAIR: It doesn't occur in private practice. It doesn't occur anywhere. You have the patient that comes in, they're admitted by one doctor. After their shift is over, the next doctor comes in. So, that's why you see everybody in the practice for your prenatal care.

ASSEMBLYMAN IMPREVEDUTO: Exactly right.

DR. ADAIR: So continuity of care, to me, is, "I'm your physician. I'm explaining to you what's going on, what my plan is for you, and I have conference with my colleagues who will be taking over so that there is no discrepancy in what the plan is." That's continuity of care. It doesn't matter if it's the same person. If you have the same person who doesn't give you any information, and you have no clue what's going on with you, that's really not care to me. Care is communication.

And as a surgeon, we all look back and -- even me, I stand here now and I have people, my junior residents, who are, you know, having issues of being up, can't be home with their families. And as an intern, I just did what I thought I was supposed to do. And I think that some of the people who trained prior to all of these new legislations feel kind of, you know, I guess a little slighted or upset that, "How dare they? If we did it, everybody else can." But again, you know, that doesn't make it right.

ASSEMBLYMAN IMPREVEDUTO: It's kind of like the fraternity thing. We went through the hazing, therefore everybody should go through the hazing.

ASSEMBLYMAN AHEARN: Hazing, yes. I went through the same thing in the airborne. I went through the hazing. I know it very well, the hazing ritual.

ASSEMBLYMAN IMPREVEDUTO: Yes, you went through boot camp. It should be the same way. But we don't practice rocking in a rocking chair because we're going to get old, you know, so I agree with you.

Thank you for sharing your testimony with us.

DR. ADAIR: Thank you.

ASSEMBLYMAN IMPREVEDUTO: What else do you have, Larry?

Here's who we have. Bernie, we have Dr. Stephen Baker, Dr. Malik Willis--

UNIDENTIFIED SPEAKER FROM AUDIENCE: Dr. Baker had to leave, by the way.

ASSEMBLYMAN IMPREVEDUTO: Okay. Dr. Baker is gone. Bernie, you want to--

MR. GIRARD: Yes.

ASSEMBLYMAN IMPREVEDUTO: Okay.

Please do not read your testimony. I kind of got away from that, but it's getting late.

MR. GIRARD: I'm not going to. Assemblyman, yes. In light of the time, I will be brief.

I want to thank you very much for the opportunity to speak before you today. My name is Bernie Girard. I'm a Registered Nurse, and I'm the Vice-President of the Health Professionals and Allied Employees, and I'm a Registered Nurse. I also thought I was part of the Special Forces because I worked for 12 years as a critical care nurse at this institution at the surgical/trauma intensive care unit.

I know these residents work long hours. You've heard that today. And I just wanted to speak briefly that it's dangerously ironic that medicine, nearly universally, resists restrictions on the work hours of its caregivers even though it's clearly a patient safety issue.

Very recently, as legislators know, nurses battled to end the onerous practice of forced overtime. We believed that patient care was being compromised, and the legislators agreed. They agreed to ban the practice of overtime and end it by 2002.

Physicians-in-training are chronically sleep deprived, yet we expect them to provide quality care to their patients while they are learning at the same time.

I salute you as the sponsor and Dr. Munoz.

And thank you.

ASSEMBLYMAN IMPREVEDUTO: Thank you, Bernie. I appreciate it. And I apologize for mispronouncing your first name before.

Bridget Devane. Bridget, we're sorry that you had to wait so long for--

BRIDGET DEVANE: (speaking from the audience) That's okay.

ASSEMBLYMAN IMPREVEDUTO: And we ask you just to -- you have the same problem I do. Just lower the mike so you--

MS. DEVANE: Short people syndrome.

ASSEMBLYMAN IMPREVEDUTO: There you go.

MS. DEVANE: Thank you.

ASSEMBLYMAN IMPREVEDUTO: Height-deprived. We're not short. (laughter)

MS. DEVANE: Okay.

I hope you don't have to create legislation over the language of that, but--

Thank you for holding these hearings today. It's an important issue.

My name is Bridget Devane. I represent New Jersey Citizen Action. We're the State's largest independent citizen watchdog organization. And we represent 60,000 families in the State of New Jersey, as well as 90 affiliated organizations, many of which are senior, health care, disability, tenants, environmental, religious, and a host of labor organizations.

I'll be very brief.

I'm speaking here today for many of the patients who have called us at Citizen Action, who have had problems, who may not know the details of why they were -- may have had problems in a hospital, but know that they got -- their mother got the wrong medication or that they were misdiagnosed. Those are the people that call us. And we often don't know exactly what were the details behind the situation, but we try as hard as we can to help them.

And many times it's because interns, residents, and many other health-care workers are overworked at this point. And this is a problem throughout our health-care system today. And this legislation will help to improve our health-care system, and that's why we're urging you to move this

legislation forward. It's a needed solution to this problem and we hope that you'll do so.

Thank you.

ASSEMBLYMAN IMPREVEDUTO: Thank you very much.

Sharon McAleavey. (no response)

Okay.

Dr. Malik Willis. (no response)

Dr. Malik Willis.

No.

Dr. Malhotra.

GAUTAM MALHOTRA, M.D.: I'm Dr. Gautam Malhotra.

Assemblymen, it's a please to speak to you.

I want to address -- what I heard was the origination of this bill, was that it was a personal story and a pride in New Jersey that kind of brought this about when it first started out in someone's mind. So, I'm going to address that in the beginning and in the end of what I'm going to say.

I went to grammar school in New Providence, New Jersey. I went to Pingry School for high school. Then, I went to Rutgers College in New Brunswick, New Jersey. Then, I decided to do residency here at New Jersey Medical School. And now, I'm a first year resident in internal medicine here, and I'm going on to PMNR at Kessler. These are all located in New Jersey, and these were all choices I made. So, I have a lot of pride in this State.

One thing that I want to push is the teaching aspects of our careers here. And Dr. Watson, who is a urology attending here, told me the first day I was a med student that the word doctor comes from *doceere*, which means "to

teach.” I think it’s Latin. And I kept that in my mind, and I’m grateful to be able to teach students now.

The thing is that when we’re working all day long and then all night long and then the next day -- you’ve already heard how it’s very difficult to really, like, get the meat and substance of what our attendings are trying to teach us. But the thing that separates me, as a medical resident, from a PA student is that I’m not just looking at algorithms of how to take care of a patient that comes in with *X* symptom. I also know why or I should know why this is happening and why I’m doing *A* to *B* to *C* to *D*, not just following the cookbook and the recipes. And a lot of that -- I missed out on a lot of that when I was working on rotations where I was working 36 to 48 hours straight.

I’m here at the Internal Medicine Residency, where we do have a night float system. You’ve heard Dr. Pinho talk about it. I vowed when I was a third year student here that I would not come to this institution because it was so horrible. The residents were not paying attention. It just looked like a miserable experience. And then they had the night float system, and all of a sudden I wanted to be here. So, this is a personal -- I changed my future because this night float system had showed such a big difference in the strength of the program.

So, you know, if you want people to stay in New Jersey for their training, then -- two things that doctors look at is how many patients they’re exposed to and what kind of patients and another thing they’re looking at is the quality of the didactic training and how they’re going to get to be more sophisticated and follow that whole idea of *docēre*, to teach, to learn, to go past just the cookbook.

So, I think that the people who've pushed saying that there should be some kind of legislation which talks about protected time for, you know, learning during, you know -- either turning off the pagers or that it's limited to 10 hours. I don't know exactly what details you guys are going to go for, but it really should be addressed because the sophistication of your doctors depends on that.

And that's all I have to say.

ASSEMBLYMAN AHEARN: Thank you.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

I have no further names on this list of people who would like to testify. If there's someone in this room that has not been heard that would like to be heard, please step forward. (no response)

Seeing none, I'm going to close by saying thank you to everyone who testified. On behalf of myself and my cosponsors, Dr. Munoz and Matt Ahearn, Esq., since we're using titles here.

We appreciate, Eric, you inviting us to the hospital and Dr. Cook providing us with this wonderful facility to bring this hearing to the place where it all happens.

So, thank you all and certainly a lot of your comments, many of your comments, will be taken into consideration as we move forward with this bill. New Jersey is going to have some changes.

Thank you.

Gentlemen?

ASSEMBLYMAN MUNOZ: Thank you.

ASSEMBLYMAN AHEARN: That's fine.

ASSEMBLYMAN IMPREVEDUTO: Thank you all.

ASSEMBLYMAN MUNOZ: Thank you, Chairman.

(MEETING CONCLUDED)