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Karen Lambert
Associate Executive Director
Residency Review Committee – Internal Medicine
Accreditation Council for Graduate Medical Education
515 N. State Street, Suite 2000
Chicago, IL 60654

RE: Hematology Response to 12//08 Draft of Hematology and Hematology/Medical Oncology Program Requirements

Dear Ms. Lambert:

The American Society of Hematology (ASH) is pleased to be able to submit comments on the December 2008 drafts of the Program Requirements for both the subspecialty of Hematology and for combined Hematology/Medical Oncology programs.

ASH appreciates the efforts of the Residency Review Committee in this endeavor and acknowledges its outreach to the specialty societies during the review process. The revised document has many positive modifications. For the purposes of feedback, we are limiting our comments here to the areas where we have concerns.

Our concerns are listed in order of importance and reflect issues that we have not previously brought to the attention of the RRC as these changes were not evident in earlier iterations of the program requirements:

1) The deletion of "test of hemostasis" on line 905 of the Hematology Program Requirements and omitted in the Hematology/Medical Oncology Requirements is concerning and, we feel, inappropriate. Earlier versions of the new Program Requirements had already moved this from its current level of "The program should provide formal instruction and clinical experience of the following" to one of the areas a fellow "should <u>be provided with</u> experience or observation of the following." We are concerned by the deletion of this aspect of hematology that is critical for understanding how to evaluate and manage hemostasis disorders. We strongly request that the principle of "tests of hemostasis" be reinstated into both the Hematology and the Hematology/Medical Oncology Requirements, with new language to emphasize the importance of learning "the principle and basic operation of tests of hemostasis."

2) As hematologists, we are troubled by the proposed wholesale deletion (lines 719-725) of "performance and interpretation of the following, complete blood count, including platelets and white cell differential, by means of automated or manual techniques, with appropriate quality control;" from the list of procedures a fellow must "develop competence in" in the Hematology/Medical Oncology Requirements (it remains in the Hematology Requirements). This is noted as a deletion proposed by the American Society of Clinical Oncology (ASCO) which will be discussed by the RRC. Combined hematology/medical oncology training programs must still provide hematology training that is appropriate for the practice of hematology. Competency in these skills is at the foundation of the practice of hematology. While we argue strongly that this requirement remain in the provided training curriculum, we would support a modification in the language to place emphasis on *interpretation* of the complete blood count, rather than the actual performance of the procedure.

3) We propose the deletion of lines 618-619 ("At least 50% of the clinical training must occur in the outpatient setting.") from the Hematology program requirements. Our understanding is that this been inserted at the request of a specific subspecialty, and while we appreciate the importance of emphasizing training in an outpatient setting when it is appropriate, we cannot support the universal inclusion of this requirement, especially using the ACGME imperative "must". This can be included in the appropriate subspecialty's program requirement and identified as being solely the requirement for that subspecialty, or if left in all program requirements, it should be changed from "must" to "may," which will allow programs to grow experiences as they deem fit and not require changes that could be detrimental to a particular specialty's training. Many hematology patient care experiences are unique to the inpatient setting and cannot be reproduced in the outpatient setting. In particular, major components of the active management of acute leukemias and stem cell transplantation are primarily inpatient experiences. Inpatients develop acute changes of blood counts and the onset of coagulation disorders (e.g. bleeding, coagulopathies, thrombosis) that are the result of other medical conditions and treatments that are not seen in the outpatient setting. Clearly, the consultative and primary patient care education of fellows would be adversely affected if they were not able to have an adequate level of these experiences because of a relatively high outpatient environment requirement. We agree that a 50% expectation <u>may</u> be more appropriate for some other subspecialties, like medical oncology. In summary, we feel strongly that the proposed outpatient experience requirement would be significantly detrimental to Hematology education. However, for the combined Hematology/Medical Oncology Requirements, we would be agreeable to placing the expectation that "50% of medical oncology component of training should be in the outpatient setting."

4) We have a few comments and suggestions regarding the "scholarly activity" sections of both the Hematology and Medical Oncology Requirements (lines 334-356 of the Hematology Requirements and lines 335-354 of the Hematology/Medical Oncology Requirements for faculty; and lines 1104-1119 of the Hematology Requirements and lines 1177-1192 of the Hematology/Medical Oncology Requirements).
   a) We greatly appreciate the RRC's decision to include "Quality Assurance assessment initiatives" into the Hematology scholarly activity list. We believe

that this should be included in the list for the Hematology/Medical Oncology Requirements as well.

b) We strongly recommend that "Education Research" be included in the list of acceptable scholarly activity for faculty. This will give appropriate recognition of the academic importance of this type of work. Further, this is recognized as "scholarly activity" for fellows (line 1114 of the Hematology Requirements and line 1187 of the Hematology/Medical Oncology Requirements) already.

c) Since Quality Assurance assessment initiatives (and hopefully education research) are recognized as acceptable "scholarly activity", we suggest modification of lines 361-362 of the Hematology Requirements and lines 359-360 of the Hematology/Medical Oncology Requirements to include (add) language, such as "peer-reviewed publication or presentation at regional or national meetings of performance improvement or education research," to recognize these as acceptable measures of academic productivity for these scholarly activity areas. This would also be consistent with what is already stated as acceptable for fellows.

5) We object to the addition of language under the stem "The program director must." On line 302 of the Hematology Requirements (line 303 of the Hematology/Medical Oncology Requirements) is the additional responsibility that the program director must "u) assure the academic progress of fellows during their training." While we commend the spirit behind this insertion, we believe this is implied in all other language of the program requirements and this insertion adds nothing to the document. It also implies that the program director could be held personally responsible for fellows that don't adequately progress academically, when the "problem" may be inherent to the fellow. It is already an expectation that the program director needs to oversee the assessment of their fellows and to educationally remediate those fellows who are not meeting competency benchmarks set by the program. The word "assure" in the proposed requirement is problematic. We encourage deletion of this proposed requirement.

6) On line 583 of the Hematology Requirements (line 577 of the Hematology/Medical Oncology Requirements), we request that you not change "may" to "will". The program director cannot be expected to make definitive decisions for the American Board of Internal Medicine (ABIM) and, therefore, is not in a position to determine what "will" affect a fellow's eligibility for certification versus what "may" affect a fellow's eligibility based on the program director's interpretation and understanding of ABIM policies and requirements.

7) Line 731-733 of the Hematology Requirements states an expectation that Hematology and Hematology/Medical Oncology training programs will be responsible for their fellows developing competence in the "interpretation of CSF fluid". As there are several diseases in which evaluation of the CSF is important, including those that are not hematology or medical oncology diseases, it is inappropriate to expect Hematology or Hematology/Oncology training programs to be responsible for training their fellows to the point of developing competence in the "interpretation of CSF fluid," without a

qualifier that this is limited to "those findings relevant to hematology (or medical oncology for Hematology/Medical Oncology programs) diseases."

8) The competency requirements stated in lines 735-738 of the Hematology Requirements (lines 740-743 of the Hematology/Medical Oncology Requirements) are redundant and are limiting by specification of a specific type of CSF reservoir system that may not be used in all institutions or that may be modified and called something else in the future. We suggest combining these requirements as, "administration of chemotherapeutic agents intrathecally via lumbar puncture and via implanted CSF access devices (e.g. Ommaya reservoir)."

9) Regarding the addition of the "morbidity and mortality (or quality improvement)" conferences in lines 755-756 of the Hematology Requirements (lines 773-774 of the Hematology/Medical Oncology Requirements). We suggest broadening the language, deleting "morbidity and mortality (or quality improvement)" to read "organized opportunities for fellows and faculty to review patient safety and unexpected patient outcomes." We encourage broadening the language as some programs may have unique venues, other than formal 'conferences', in which to conduct these reviews and discussions.

We would also like to reiterate the recommendations made earlier on behalf of ASH's Committee on Training Programs and request that these be given due consideration.

Line 92: Not all programs have the resources (financial and institutional infrastructure) to have access to training simulators. The decision to use this teaching method should be left to the individual programs.

Line 94: The RRC should not dictate what medical records system is used by a hospital. There are many factors that go into the decision of what system to use. Fellows should be expected to understand how to use the medical record system(s) at their training site(s).

Line 157: No other RRC sets an expectation of time as faculty before being eligible to be a program director. The rationale for this requirement remains undefined. In recognition that the RRC favors some requirement, however, we propose to change this to three (3) years.

Line 362: We appreciate the RRC acknowledging the importance of "patient care quality assurance assessment initiatives" and honoring our suggestion to include it as a way for faculty to demonstrate scholarship. We request that (5) be added with (1) and (2) as a demonstration of key clinical faculty's productivity.

Line 1395: The justification of this policy, which is more restrictive than the residency program's policy, is unclear. We recommend deleting it.

In closing, we'd like to comment on two issues:

The efforts of the program directors deserve recognition by their institution. However, without the support of the RRC, in the form of specific language in the program requirements, the program directors will continue to be pressed into service in too many areas. We are concerned that the RRC did not include the supportive language we suggested in our September submission, but rather chose to continue to mandate that program directors have many responsibilities, while not mandating that the institutions provide the "protected time" or support necessary to carry out the requirements.

We would also like to go on record as objecting to the language regarding the evaluation of training programs based on fellows taking and passing the American Board of Internal Medicine specialty examinations. The program director has no control over who takes or passes an exam(s). This metric might be able to be used as a program evaluation tool, but the language as it currently stands continues to be troubling.

Once again, we acknowledge and appreciate the efforts of the RRC over the course of this review and revision process, especially in their effort to become less prescriptive with the program requirements.

Please do not hesitate to contact Scott Gitlin, MD, the Chair of ASH's Committee on Training Programs (sgitlin@umich.edu) or ASH staff (kkayoumi@hematology.org) if you have any questions or concerns, or would like to discuss any of these matters further.

Sincerely,

Nancy Berliner, MD
President