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**2010**

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**RE: Hematology Response to 12//09 Final 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 final drafts of the Program Requirements for both the subspecialty of Hematology and for combined Hematology and Medical Oncology programs.

We appreciate and acknowledge the efforts of the RRC during this revision, especially the efforts of Drs. Jeanette Mladenovic and Glenn Mills on behalf of hematology and medical oncology. We appreciate the reversal of the decision to remove complete blood count from the list of procedures in which a fellow in combined hematology/medical oncology training must demonstrate competence.

Upon review of the proposed new Hematology and Hematology/Oncology Program Requirements, we have several matters which we would like to highlight (line numbers refer to those from the hematology program requirements, unless stated otherwise). Our concerns are listed by priority; this list reflects both crucial issues we've already brought to the attention of the RRC and new concerns voiced by program directors.

1. Of primary concern is the continued inclusion of the requirement that 50% of training be completed in an outpatient setting. We, again, ask for the deletion of lines 961-962 ("At least 50% of the clinical training must occur in the outpatient setting.") from the Hematology program requirements.

In the Summary and Impact of Major Revisions document for hematology, regarding this change it states "Currently the practice of medical oncology has changed to primarily outpatient management of cancer patients. The Program Directors committee recommended to the RRC-IM that outpatient education in hematology needed to be increased to meet this change in practice patterns. This proposed requirement will better train fellows to the practice demand of the future."

While it may be true that the practice of MEDICAL ONCOLOGY has changed to primarily outpatient management of cancer patients, that is not true for the practice of HEMATOLOGY, which has a very significant proportion of its clinical practice and training in an inpatient setting. In addition, far from

recommending this, the ASH Committee on Training Programs has, on multiple occasions, asked for the removal of this requirement from the hematology program requirements, and the rewording of the requirement in the combined hematology/medical oncology requirements (lines 1028-1029), to reflect that this is only for the medical oncology component. ASH also recommends that the “must” be changed to “may”.

2. As we stated in our January 16, 2009 letter, the deletion of “test of hemostasis” on line 1004 of the Hematology Program Requirements and omission in the Hematology/Medical Oncology Requirements is troubling 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 be provided with 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.”
3. In lines 1025-1026 of the combined hematology and medical oncology requirements, the RRC has broken down the previously stated 18 months of clinical training into nine months for hematology and nine months for medical oncology. The rationale provided is that this *ensures fellows receive adequate clinical training in both hematology and medical oncology*. The flaw in this reasoning is that malignant hematology commonly falls under both medical oncology and hematology. ASH would propose that lines 1025-1026 of the hematology/medical oncology requirements read, “Of this time, nine months must be in hematology and nine months must be in medical oncology with the goal of providing clinical experiences that balance non-malignant hematology, malignant hematology and solid tumor oncology.”

If a 50% outpatient requirement is implemented, then this should be limited only to the solid tumor oncology clinical experiences (although this, too, may be inappropriately restrictive for the structure of some programs).

4. We request a change in the requirement for access to simulation teaching models, as stated on line 968 (line 1035 of the hematology/oncology requirements). Not all programs have the resources (financial and/or institutional infrastructure) to have access to training simulators. Additionally, not all hematology procedures are amenable to a simulator, either because of lack of availability of actual simulators for certain procedures, or unique characteristics of the procedure that does not lend itself to a simulator which ultimately makes this an unreliable teaching method. It is premature to require this of all training programs, especially since instead of focusing on an outcome or competency, this prescribes use of a specific teaching tool; a matter which should be left up to the individual training program.
5. We object to lines 360-365 (lines 364-368 of the combined hematology/oncology requirements), which state that one Key Clinical Faculty should be trained in the evaluation and assessment of the ACGME competencies. We are not aware of programs to train and certify faculty in this regard. We are concerned about potential conflicts if the ACGME mandates training for evaluation of ACGME competencies and then the ACGME offers courses to provide said training. Additionally, it is unclear where the funding for this position will come from. This function is currently generally carried out by the training program

director. If specific skills and training are needed, it should be part of a core requirement under the auspices of the residency program, not replicated 10 times in each fellowship. It is premature to mandate this position and this needs to be further defined as to who is expected to do this, what expectations are there for salary support and protected time for this person(s), what role this person has in the training program as a whole, etc.

6. We ask that a qualifying statement be included to indicate that the fellow is responsible for this knowledge as it pertains to the specialty. Lines 710-711 (lines 743-744 of the hematology/oncology requirements) reads “performance of lumbar puncture and interpretation of CSF fluid evaluation,” 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 the Hematology/Medical Oncology program requirements) diseases.
7. Regarding lines 40-45 (lines 42-47 of the hematology/oncology requirements), that discusses the salary support of the program director; ASH has long been a supporter of the need for recognition and institutional support of the program director. We are, however, concerned about the RRC’s comment in the Summary and Impact of Major Revisions for this change. In point four, the RRC states that this should not have any financial impact on institutions; we believe it is shortsighted of the RRC to not anticipate that this will be an issue at many programs, despite the previous iterations of this requirement.
8. ASH would like clarification on the role of the associate program director. It is commendable that the RRC has formalized and recognized this role for fellowship training. However, we are concerned about the funding of this position; specifically how the effort of the associate program director will be reported and the very real possibility that in order to keep the program director’s supported time at a minimum; the associate program director may, in the end, have an inordinate share of the workload, especially at a lower salary rate. There needs to be clarification regarding salary support expectations for both the Program Director and the Associate Program Director.
9. In lines 970-974 (lines 1037-1041 of the hematology/oncology requirements), the RRC provides a detailed list of tasks related to functioning in a practice setting. We believe this should be handled on an institutional level and not by the individual fellowship. This list could quickly become dated and assumes that all programs and practices function identically, which is not the case. Also, this list of topics may not be appropriate for those fellows who pursue an academic career.
10. Lines 426-429 (lines 428-431 of the hematology/oncology requirements) require “Inpatient and outpatient systems must be in place to prevent fellows from performing routine clerical functions, such as scheduling tests and appointments, and retrieving records and letters.” We suggest a subtle change in this language, to read: "Inpatient and outpatient systems must be in place to prevent fellows from performing routine clerical functions, such as scheduling tests and appointments, and obtaining outside records and letters." This change reflects the realities of the work environment while preserving the focus on patient care vs. administrative activities.

11. ASH seeks clarification on the addition of the word “Direct” in lines 1051-1053 (lines 1114-1116 of the hematology/oncology requirements) when referring to supervision by faculty. For many procedures, physician assistants or nurse practitioners play an active role in the training of fellows and function as the “one faculty” member for teaching purposes. The current language is too restrictive; we suggest that this language be changed to “skilled preceptor”, rather than “faculty”.
12. ASH would like to remind the ACGME that American Board of Internal Medicine (ABIM) certification is a *voluntary process*. The multiple program requirements that either mandate ABIM certification for program directors and key clinical faculty or evaluate a program based on the ABIM certifying exam pass-rate for program graduates impose penalties on the program for actions of an individual and for which the training program has no control. For example, a physician with a D.O. or international degree, who would not be easily eligible for the ABIM certifying examination.

We continue to object to the language regarding the evaluation of training programs based on fellows taking and passing the ABIM specialty examination. 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. Finally regarding the ABIM, on lines 519-520 of the hematology requirements (521-522 of the combined requirements), we again ask for the change from “will” back to “may”. As we pointed out in our previous response, the program director cannot be expected to make definitive decisions for the 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.

13. Lines 58-59 (lines 59-60 of the hematology/oncology requirements) have added the requirement that “appropriate inpatient and outpatient faculty performance data” are shared with the program director. While ASH is firmly behind quality improvement activities, we believe this particular function is better served at a level above the fellowship program director, e.g. Division Chief or Department Chair. The program director is not necessarily in a position to implement independent continuous quality improvement activities outside of the institutional norms. The sharing of this type of information with the program director, or others, also raises concern about privacy for the individual faculty members. We believe that this responsibility lies within the management of the institution and is not under the specific purview of a program director.
14. ASH is concerned that the ACGME has removed language from the previous draft version of the requirements which would allow “quality assurance assessment activities” to fall under the umbrella of “scholarly activity.” We ask that this be reinstated and be included as a demonstration of key clinical faculty’s productivity, as well as fellow productivity. This can be found on lines 352-356 (1076-1077 for fellows) and lines 1076-1077 of the hematology requirements (lines 1143-1144 of the hematology/oncology fellows’ requirements)
15. There is an inconsistency between the hematology and the hematology/oncology requirements at lines 448-450 and 450-451, respectively. We advocate that there should be access to specialized coagulation laboratory present at the training site(s).

16. Lines 997-999 (lines 1067-1069 of the hematology/oncology requirements) should read, "...as well as other standard and specialized coagulation assays..." The inclusion of specialized coagulation assays would be appropriate for those training in hematology.

Thank you for the opportunity to comment on these changes in specialty training. This new iteration has the potential to change the face of training; we appreciate both the time the RRC has spent in drafting this document and your careful consideration of our comments in response to those changes.

Please do not hesitate to contact Scott Gitlin, MD, the Chair of ASH's Committee on Training Programs ([sgitlin@umich.edu](mailto:sgitlin@umich.edu)) or Karen Kayoumi, ASH's Senior Manager for Training and Evaluation ([kkayoumi@hematology.org](mailto:kkayoumi@hematology.org)) if you have any questions or concerns, or would like to discuss any of these matters further.

Sincerely,



Hal E. Broxmeyer, PhD  
President



J. Evan Sadler, MD, PhD  
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