February 1, 2016

Thomas J. Nasca, MD
Chief Executive Officer
Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60654

Dear Dr. Nasca:

The American Society of Hematology (ASH) appreciates this opportunity to provide input regarding the Accreditation Council for Graduate Medical Education’s (ACGME) requirements for the learning environment and duty hours for residents and fellows. ASH represents over 15,000 clinicians and scientists committed to the study and treatment of blood and blood-related diseases. ASH also has over 1,700 Associate members, hematologists-in-training who are directly impacted by the policies of the ACGME.

Training program directors for hematology training programs, including combined adult hematology/oncology training programs, as well as pediatric hematology/oncology, transfusion medicine, and hematopathology are represented by ASH’s Committee on Training.

ASH would like to take this opportunity to comment on four key points with ACGME:

1. ASH strongly supports the FIRST and iCOMPARE trials currently underway. The Society recognizes the value of these trials in informing decisions about duty hour and learning environment standards. The Society encourages ACGME to embrace a timeline and process for revising its duty hour standards that reflects the release of data from these and other studies of duty hours. Therefore, ACGME should not wait another five years to revise the duty hour and learning environment standards if actionable data emerge from these studies.

2. Our ongoing concern with duty hour requirements is whether they allow adequate preparation of residents for a career in clinical practice or for subspecialty training. We share the concerns about the possible negative effects of these requirements on education that have been noted in reports such as “A Narrative Review of High-Quality Literature on the Effects of Resident Duty Hours Reforms” in the January 2016 Academic Medicine and “The Effect of Restricting Residents’ Duty Hours on Patient Safety, Resident Well-Being, and Resident Education: An Updated Systematic Review” in the September 2015 Journal of Graduate Medical Education. We agree with the authors of these publications that the duty hour requirements may very well limit residents’ knowledge acquisition, skill development, and cognitive performance. Because of the findings in these reports, the Society cautions ACGME against making duty hour requirements any more restrictive. It is also important that individual Residency Review Committees remain mindful of the need for adequate preparation of residents for their post-graduate plans when crafting the requirements for residency training.
3. Program directors report that the duty hour changes have compromised interns’ ownership of patient care while moving this important experience “upstream” to more experienced residents and fellows. The appropriate professional development of residents requires their ownership, under supervision, of patient care responsibilities, while the professional development of fellows requires their work in owning responsibilities for patients for whom they are the principal provider and in providing consultative services when applicable. The upstream movement of ownership threatens the professional development of both residents and fellows. Changes to the duty hour requirements, or to the manner in which institutions are implementing these requirements, should be sought to address these concern.

4. Restrictive duty hour requirements can create challenges to training by limiting the time available to learn about patient care and research. ASH appreciates ACGME’s steps under the Next Accreditation System to de-emphasize process requirements thereby allowing training programs some flexibility while they design training schedules that fit within the duty hour constraints. However, some other key requirements beyond duty hours are necessary to maintain. The ACGME should focus on strengthening the requirements dedicated to mastery of cognitive skills and procedures of the specialties. Mindful of the need to address these key requirements, the focus should be on strengthening the requirements that are most important and beneficial to residents and patients, while eliminating or lessening those that are not crucial to patient safety.

With regard to strengthening a key requirement, the Society proposes a modification of the Program Requirements for Hematology and Medical Oncology, specifically “IV.A.6.a).(1) Of this time, nine months must be in hematology and nine months must be in medical oncology.” ASH believes the division of the 18 months of dedicated clinical experience within combined fellowships should be six for non-malignant hematology, six for malignant hematology and six for medical oncology. We feel the current language combined with the demands of fellows and the implications of limited training time to meet duty hour requirements jeopardizes the time devoted to non-malignant hematology, which is a core area of preparation for fellows who wish to be adequately trained in both hematology and oncology.

On a final note, ASH would be honored to take part in the March 2016 meeting if the Society’s participation would be of value to the proceedings.

Thank you for the opportunity to comment on these issues. Please do not hesitate to contact ASH Senior Director of Education and Training Charles P. Clayton (cclayton@hematology.org) if you would like to discuss any of these matters further.

Sincerely,

Charles S. Abrams, MD
President