This Manual is meant to compliment the Housestaff Policies and Procedures manual of the University of Kansas School of Medicine and Medical Center. Residents should also refer to the written Residency Curriculum of the Department of Medicine. This Manual is not intended to be all inclusive, but rather an introduction to areas the Department considers important and of interest to its housestaff.
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INTRODUCTION TO THE

UNIVERSITY OF KANSAS MEDICAL CENTER

ELECTROPHYSIOLOGY FELLOWSHIP PROGRAM

The Division of Cardiovascular Diseases/Mid America Cardiology will provide qualified physicians with a balanced, structured, and scholarly experience in clinical and experimental cardiology.

The faculty in the Division of Cardiovascular Diseases along with Mid-America Cardiology will train fellows in every aspect of academic cardiovascular medicine. The training includes a curriculum in patient care, teaching, and the use of noninvasive and invasive techniques in cardiovascular diagnosis. The fellowship consists of one year of training, at the end of which the fellow will have met the requirements for the qualifying board examination in electrophysiology.

The lines of responsibility and curriculum reflect the ACGME guidelines regarding the six general competencies, goals, and objectives for each rotation, learning activities, and evaluation tools.

University of Kansas Medical Center Mission Statement

The University of Kansas Medical Center, an integral and unique component of the University of Kansas and the Kansas Board of Regents system, is composed of the School of Medicine, located in Kansas City and Wichita, the School of Nursing, the School of Allied Health, the University of Kansas Hospital in Kansas City, and a Graduate School. The KU Medical Center is a complex institution whose basic functions include research, education, patient care, and community service involving multiple constituencies at state and national levels. The following paragraphs chart the KU Medical Center’s course and serve as a framework for assessing programs, setting goals, developing initiatives and evaluating progress.

The University of Kansas Medical Center is a major research institution primarily serving the State of Kansas as well as the nation, and the world, and assumes leadership in the discovery of new knowledge and the development of programs in research, education, and patient care. The KU Medical Center recognizes the importance of meeting the wide range of health care needs in Kansas – from the critical need for primary care in rural and other underserved areas of the state, to the urgent need for highly specialized knowledge to provide the latest preventive and treatment techniques available. As the major resources in the Kansas Board of Regents system for preparing health care professionals, the programs of the KU Medical Center must be comprehensive and maintain the high scholarship and academic excellence on which the reputation of the University is based. Our mission is to create an environment for:

Instruction. The KU Medical Center educates health care professionals to primarily serve the needs of Kansas as well as the region and the nation. High quality educational experiences are offered to a diverse student population through a full range of undergraduate, graduate, professional, postdoctoral and continuing education programs.

Research. The KU Medical Center maintains nationally and internationally recognized research programs to advance the health sciences. Health related research flourishes in a setting that includes strong basic and applied investigations of life processes, inquiries into the normal functions of the human body and mechanisms of disease processes, and model health care programs for the prevention of disease and the maintenance of health and quality of life.
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Service. The KU Medical Center provides high quality patient-centered health care and health related services. The University of Kansas Medical Center will be the standard bearer in the development and implementation of model programs that provide the greatest possible diversity of proven health care services for the citizens of Kansas, the region and the nation.

1.2 University of Kansas School of Medicine Mission, Vision, and Values Mission
The University of Kansas School of Medicine commits to enhance the quality of life and serve our community through the discovery of knowledge, the education of health professionals and by improving the health of the public.

Vision
The University of Kansas School of Medicine will work with its partners to become the premier academic medical center in the region known for its excellent education, innovative scientific discovery, outstanding clinical programs and dedication to community service. It will be known as the place where everyone wants to come to learn, to teach, to conduct research and to receive his or her health care.

Values
Excellence
Partnership and Collaboration
Teamwork and Participatory Decision Making
Ethics, Honesty and Respect
Practicality and Financial Responsibility
Openness and Transparency in Decisions and Finances
Accountability and Measurable Milestones

Lines of Responsibility for Clinical Cardiac Electrophysiology Fellows

1. Clinical Cardiac Electrophysiology Fellows will report all complications or emergencies to the staff physician assigned to that patient.

2. Clinical Cardiac Electrophysiology Fellows who perform an invasive procedure will report any complications or emergencies to the staff physician who performed the procedure or to the CCEP staff on call.

3. Clinic Cardiac Electrophysiology Fellows who perform a stress test will report any complications or emergencies to the CCEP staff physician responsible for that patient.

4. Clinical Cardiac Electrophysiology Fellows receiving calls from the Emergency Department or from outpatients after hours will report all complications or emergencies to the CCEP on-call physician. A schedule for CCEP staff on-call responsibilities is prepared prior to the start of each month and provided to each CCEP staff and fellow.

5. Clinical Cardiac Electrophysiology Fellows having any difficulty communicating with the CCEP staff physician assigned to a given area will contact the CCEP program director or another appropriate available attending physician.

6. Clinical Cardiac Electrophysiology Fellows will answer their pagers promptly when not performing a procedure, or within a reasonable period of time when outside the hospital during off-hours. If they are performing a procedure, fellows will have someone else answer the page promptly.

7. Moonlighting is not permitted for Clinical Cardiac Electrophysiology Fellows who have on-call responsibilities. All CCEP fellows who moonlight will review the moonlighting specifications of the University of Kansas School of Medicine as specified in the GME Housestaff Policy and Procedure Manual.
The University of Kansas Medical Center
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8. CCEP fellows may be contacted by cardiovascular fellows, internal medicine residents or family medicine residents on the cardiology service concerning new admissions or complications. In general, CCEP fellows may at times supervise these residents. The CCEP fellows, in turn, will communicate all significant problems or developments to the appropriate CCEP faculty.

9. At times, a CCEP fellow may be the first physician to respond to an emergency concerning any patient. The CCEP fellow in such a circumstance will provide care and order appropriate diagnostic testing in the best interest of the patient. The attending physician in charge of the patient will be immediately notified.

10. Fellows will submit their work hours via the system generated by the KU Office of Graduate Medical Education and will adhere to the work hour limits generated by ACGME (www.ACGME.org).

The University of Kansas Medical Center Policies for Electrophysiology Fellows

1. All fellows are expected to clear time off for vacations and meetings with the fellowship coordinator in the office. Vacations and time off for meetings are generally permitted on a first-asked, first-granted basis. Unless there are extenuating circumstances, vacations or meetings during the last week in June are not permitted. Fellows are permitted three weeks of vacation per year. Meetings and vacations must be arranged three months in advance.

2. Meetings are permitted if financing is available through unrestricted grants. Attendance at local and regional meetings is encouraged.

3. Fellows will be on location between 7:00 a.m. and whenever clinical research duties are over (at earliest, 5 p.m.). Notify the fellowship coordinator for any unexpected departures during the day, such as needing to pick a child up from day-care, etc. Be collegial. Try to help other fellows who may be inundated so that everyone can finish their work at a reasonable time.

4. Non-Invasive Imaging Conference at 12:00 pm on Wednesdays is recommended.

5. Fellows will respond promptly when paged. If the fellow is in a procedure, he/she should ask someone else to respond, or have one of the technicians/nurses hold your pager during the procedure.

6. Fellows will always be knowledgeable of lines of supervision and lines of communication. In other words, if there is a complication following an exercise test, the fellow will communicate with the staff assigned to supervise non-invasive tests. If there is a patient on inpatient service who deteriorates, the fellow will communicate with the staff inpatient service. Important calls from outside the hospital will be relayed to the staff physician on-call. Complications with an invasive procedure will be discussed with the staff cardiologist who performed the procedure, or the cardiology staff on-call.

7. Use your judgment when dealing with pharmaceutical/vendor representatives. The vendor representatives do not have free access to cardiovascular areas. They must first check in either with the MAC receptionist or the receptionist in 1001 Eaton, before being permitted to enter these areas. All grants from vendor representatives need to be unrestricted.

8. Remember, you represent the Division of Cardiovascular Diseases, Mid-America Cardiology and the Department of Internal Medicine. Be especially collegial, helpful, and friendly to all consultants and allied health professionals. Report promptly any incident reports or problems to the respective cardiology staff.
RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR (PR VI.D.1)

Classification Levels of Supervision:

a. Direct Supervision: the supervising physician is physically present with the fellow and patient
b. Indirect Supervision with direct supervision immediately available: the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision
c. Indirect Supervision with direct supervision available: the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide

d. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

OPTIMAL CLINICAL WORKLOAD (PR VI.E.)

This rotation is a rotation during which the fellows acquire expertise and skill in evaluation of all types of cardiac arrhythmias including supraventricular and ventricular arrhythmias and invasive evaluation including diagnostic electrophysiological studies and ablation treatment of supraventricular and ventricular arrhythmias. Fellows receive training in the use of antiarrhythmic drugs.

Basic electrocardiography is reviewed as well as cardiac cellular electrophysiology. Indications for electrophysiologic testing including tilt table testing are reviewed. Complications of electrophysiologic testing are reviewed.

The acute and chronic treatment of patients with supraventricular and ventricular arrhythmias is taught including diagnosis and management of atrial fibrillation, diagnosis and management of AV nodal reentrant tachycardia’s, nonparoxysmal junctional tachycardias, atrial tachycardias, permanent junctional reciprocating tachycardias, and atypical AV reentrant tachycardia.

Ventricular tachycardia is also reviewed in detail including arrhythmogenic right ventricular dysplasia, hypertrophic cardiomyopathy and tachycardia, ventricular tachycardia in patients with a structurally normal heart, the long QT syndrome and polymorphic ventricular tachycardia.

The patients are instructed in the programming and follow-up surveillance of permanent pacemakers and ICD’s.

Fellows are expected to observe and be involved in 3 to 4 EP studies for VT assessment, an average of 2 device implantations per week, 1 atrial fibrillation, 1 atrial flutter ablation, 2 to 3 SVT ablations, device extractions, 2 to 3 tilt table tests, at least 10 device checks, outpatient clinic two days a week, in-patient consults to be reviewed by the attending on call.

MEMBERS OF THE INTERPROFESSIONAL TEAM (PR VI.F.)

Supervision of Fellows

a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of fellows at all times. Fellows must be provided with rapid, reliable systems for communicating with supervising faculty.

b. Faculty schedules must be structured to provide fellows with continuous supervision and consultation.

c. Faculty and fellows must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

COMPETENCIES TO ALLOW PGY1 RESIDENTS TO PROGRESS TO INDIRECT SUPERVISION (PR VI.D.5.a),(1)

N/A

DEFINING RESIDENT LEVELS “INTERMEDIATE LEVEL” & “FINAL YEARS OF TRAINING” For establishing the minimum rest period between duty periods (PR VI.G.5.b&c)

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in
patient care delegated to each fellow must be assigned by the program director and faculty members. The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

Faculty members functioning as supervising physicians should delegate portions of care to fellows based on the needs of the patient and the skills of the fellows. Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. Senior-level residents will be defined by each ACGME RRC, but generally includes residents in their final years of education. It is desirable that senior-level residents have 8 hours free of duty between scheduled duty periods. Each ACGME RRC will define specific circumstances when senior-level residents may stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of duty. Circumstances of return-to-hospital activities with fewer than 8 hours away from the hospital by the senior-level residents must be monitored by the Program Director.

**CIRCUMSTANCES WHEN RESIDENTS IN THEIR FINAL YEARS OF EDUCATION MAY REMAIN OR RETURN IN < 8 HOURS (PR VI.G.5.c).**

The majority of RRCs define these circumstances as “required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family

**DEFINED MAXIMUM NUMBER OF CONSECUTIVE WEEKS AND MAXIMUM NUMBER OF MONTHS PER YEAR OF IN-HOUSE NIGHT FLOAT (PR VI.G.6.)**

N/A

**Program-specific guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty (PR VI.D.5)**

1. Admission to Hospital – The decision of admission to hospital will be done with Direct Faculty Supervision.
2. Transfer of patient to a higher level of care
3. End-of-Life decisions should be communicated to attending physician at the time of the decision and documented in the chart.

**Source of specific criteria and/or specific national standards-based criteria used to evaluate each resident’s abilities (PR VI.D.4.a)**

The Electrophysiology program has an effective plan for assessing electrophysiology fellow performance throughout the program and for utilizing the results to improve electrophysiology fellow performance.

This plan includes the use of methods that produce an accurate assessment of electrophysiology fellows’ competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice and mechanisms for providing regular and timely performance.

Feedback to electrophysiology fellows includes a quarterly evaluation that is communicated to each electrophysiology fellow in a timely manner and the maintenance of a record of evaluation for each electrophysiology fellow that is accessible to the fellow. The Program Director and the Evaluation Committee in the Division of Cardiovascular Diseases and Mid-America Cardiology assess results to achieve progressive improvements in electrophysiology fellows’ competence and performance. Sources of evaluation include faculty, patients, peers, self, and other professional staff. The program director and the Evaluation Committee will provide a final evaluation for each electrophysiology fellow who completes the program. The evaluation includes a review of the electrophysiology fellow’s performance during the final period of education and verifies that the electrophysiology fellow has demonstrated sufficient professional ability to practice competently and independently. The final evaluation will be part of the electrophysiology fellow’s permanent record maintained by the University of Kansas Electrophysiology Fellowship Program.
The University of Kansas Medical Center Cardiac Electrophysiology Rotation

This is a rotation during which the fellows acquire expertise and skill in evaluation of all types of cardiac arrhythmias including supraventricular and ventricular arrhythmias and invasive evaluation including diagnostic electrophysiological studies as well as ablation treatment of supraventricular and ventricular arrhythmias. Fellows receive training in the use of antiarrhythmic drugs.

Basic electrocardiography is reviewed as well as cardiac cellular electrophysiology. Indications for electrophysiologic testing including tilt table testing are reviewed. Complications of electrophysiologic testing are reviewed.

The acute and chronic treatment of patients with supraventricular and ventricular arrhythmias is taught including diagnosis and management of atrial fibrillation, diagnosis and management of AV nodal reentrant tachycardia’s, nonparoxysmal junctional tachycardias, atrial tachycardias, permanent junctional reciprocating tachycardias, and atypical AV reentrant tachycardia.

Ventricular tachycardia is also reviewed in detail including arrhythmogenic right ventricular dysplasia, hypertrophic cardiomyopathy and tachycardia, ventricular tachycardia in patients with a structurally normal heart, the long QT syndrome and polymorphic ventricular tachycardia.

Fellows are expected to be proficient in insertion of PM, ICD, and biventricular devices. Therefore, they will participate in all aspects of Diagnosis, implantation and outpatient follow-up of these devices. The Fellow will also be educated on possible complications of device insertion. He/she will be able to communicate the relative benefits of device Rx with patients. Finally, the fellow will have the opportunity to be involved in complex lead extractions.

The patients are instructed in the programming and follow-up surveillance of permanent pacemakers and ICD’s.

Fellows are expected to observe and be involved in 3 to 4 EP studies for VT assessment, an average of 2 device implantations per week, 1 atrial fibrillation, 1 atrial flutter ablation, 2 to 3 SVT ablations, device extractions, 2 to 3 tilt table tests, at least 10 device checks, outpatient clinic one day a week and in-patient consults to be reviewed by the attending on call. At the conclusion of their Fellowship, the fellow is expected to have completed at minimum the number of procedures required to take CCEP boards. The number of cases performed as well as the fellow’s competency in completing those procedures will be reviewed at his/her six month and final summative evaluations.

The current minimum required procedures include:

1. Electrophysiologic procedures (each fellow must perform a minimum of 150 with at least 75 studies involving patients with supraventricular arrhythmias).
2. Electrophysiological evaluations of implantable antiarrhythmic devices (each fellow must perform a minimum of 25).
3. Catheter ablative procedures, including post-diagnostic testing (each fellow must perform a minimum of 75).
4. Participation in a minimum of 25 ICD implantations.
5. Participation in a minimum of 30 ICD or pacemaker revisions or replacements.
6. Participation in a minimum of 25 dual-chamber pacemaker implantations.
7. Participation in a minimum of 25 CRT (either pacing or defibrillation) implantations.
8. Device interrogation and programming, with a minimum of 100 ICDs and 100 pacemakers.

Principle Educational Goals
The principle educational goals for fellows on the Cardiac Electrophysiology Rotation are indicated in the tables below and numbered in the first column. The second column of the table lists the goal, the third column lists the most relevant learning activities for that goal, and the fourth column indicates the correlating evaluation methods.
The University of Kansas Medical Center
Electrophysiology Fellowship Program
for that goal. Specific issues that will be discussed by the attendings during the Cardiac Electrophysiology Rotation include and are not limited to those listed below.

### Legend for Learning Activities for Fellows

<table>
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<th>Internal Medicine Grand Rounds</th>
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<td>BLAM</td>
<td>Business and Legal Aspects of Medicine</td>
<td>IMMM</td>
<td>Internal Medicine Morbidity and Mortality</td>
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<td>CPC</td>
<td>Internal Medicine Clinicopathogenic Conference</td>
<td>KOF</td>
<td>Cardiology Outpatient Service</td>
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<tr>
<td>DPC</td>
<td>Direct Patient Care</td>
<td>NCC</td>
<td>Nursing Care Coordinator</td>
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<tr>
<td>DSP</td>
<td>Directly Supervised Procedure</td>
<td>NIC</td>
<td>Non-Invasive Imaging Conference</td>
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<td>FS</td>
<td>Faculty Supervision</td>
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### Legend for Evaluation Methods for Fellows

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<th>Attending Evaluation</th>
<th>PL</th>
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<tr>
<td>DSP</td>
<td>Directly Supervised Procedures</td>
<td>SE</td>
<td>End of Rotation Self Evaluation</td>
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<td>EVAL</td>
<td>Educational Committee Review (quarterly)</td>
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### A. Patient Care

#### Principle Educational Goals

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<th>Methods</th>
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<td>1</td>
<td>Bradycardia and indications for pacing.</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td></td>
<td></td>
<td>AR, DSP</td>
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<tr>
<td>2</td>
<td>Pacemaker and ICD limitations on patients who have devices.</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td></td>
<td>AR, DSP</td>
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<tr>
<td>3</td>
<td>Evaluation of patient with sudden cardiac death both primary and secondary</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<tr>
<td></td>
<td>including EP studies and T-Wave Alternans.</td>
<td>AR, DSP</td>
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<tr>
<td>4</td>
<td>Treatment of atrial fibrillation and atrial flutter. Management with rate</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td></td>
<td>control, rhythm control, anti-coagulation, new therapies such as pulmonary</td>
<td>AR, DSP</td>
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<td>vein ablation and pace and prevent atrial fibrillation.</td>
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<td>5</td>
<td>Evaluation of syncope including etiology tilt table testing as well as treatment.</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td></td>
<td>Assessment with Holters, event recorders and reveal monitors.</td>
<td>AR, DSP</td>
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<td>6</td>
<td>Evaluation of ventricular tachycardia in patients with a structurally normal heart</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td></td>
<td>and right ventricular dysplasia.</td>
<td>AR, DSP</td>
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<td>7</td>
<td>Assessment with Holters, event recorders and reveal monitors.</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td>AR, DSP</td>
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<tr>
<td>8</td>
<td>Placement of PPM and implant IDC’s including risks of procedures/ benefits.</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td></td>
<td>AR, DSP</td>
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<tr>
<td>9</td>
<td>Placement of catheters and perform diagnostic EPS.</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td>AR, DSP</td>
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<tr>
<td>10</td>
<td>Diagnosis and Ablation of renitent SVT’s (including AF, AFL, AVNRT, AVRT)</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td>AR, DSP</td>
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<td>11</td>
<td>Ability to perform and analyze device interrogan.</td>
<td>CCON (EP),</td>
<td>AE, DSP</td>
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<td></td>
<td>AR, DSP</td>
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## B. Medical Knowledge

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<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
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<tbody>
<tr>
<td>1. Assessment of intracardiac electrograms and general properties of AV node and His-Purkinje system.</td>
<td>CCON (EP), AR, DSP</td>
<td>AE, DSP</td>
</tr>
<tr>
<td>2. Supraventricular tachycardia mechanisms including reentry and enhanced automatic triggered activity. Understanding the difference between short RP versus long RP tachycardias. Types of SVTs including intracardiac arteriograms versus surface electrocardiograms and appropriate management.</td>
<td>CCON (EP), AR, DSP</td>
<td>AE, DSP</td>
</tr>
<tr>
<td>3. Cardiac cellular electrophysiology action potentials, ion channels and gap junctions.</td>
<td>CCON (EP), AR, DSP</td>
<td>AE, DSP</td>
</tr>
<tr>
<td>4. Arrhythmic diseases based on channelopathies such as Brigada, long QT and digoxin toxicity.</td>
<td>CCON (EP), AR, DSP</td>
<td>AE, DSP</td>
</tr>
<tr>
<td>5. Antiarrhythmic medication indications.</td>
<td>CCON (EP), AR, DSP</td>
<td>AE, DSP</td>
</tr>
<tr>
<td>6. Biventricular pacing, Indications reveal the literature AV optimizations. (Special considerations: narrow QRS, RBBB and mitral regurgitation.)</td>
<td>CCON (EP), AR, DSP</td>
<td>AE, DSP</td>
</tr>
</tbody>
</table>

## C. Interpersonal Skills and Communication

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communicate effectively the consult findings with physician colleagues and other members of the health care team in a timely fashion to assure a comprehensive patient care.</td>
<td>DPC</td>
<td>AE</td>
</tr>
<tr>
<td>2. Present professional findings to patient and family members in a compassionate and informative manner.</td>
<td>DPC</td>
<td>AE</td>
</tr>
</tbody>
</table>

## D. Professionalism

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interact professionally with patients, patients’ family, colleagues, and other members of the health care team.</td>
<td>DPC, AR</td>
<td>AE</td>
</tr>
<tr>
<td>2. Appreciation of the spiritual and social context of wellness and illness.</td>
<td>DPC, AR</td>
<td>AE</td>
</tr>
</tbody>
</table>

## E. Practice-Based Learning and Improvement

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commitment to scholarship and the use of evidence based cardiovascular medicine.</td>
<td>CCON (JC), NIC</td>
<td>AE</td>
</tr>
<tr>
<td>2. Broad reading of the cardiovascular literature and access and research of Medline and Internet tools.</td>
<td>CCON (JC), NIC</td>
<td>AE</td>
</tr>
</tbody>
</table>

## F. Systems-Based Practice

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understand the complexities of cardiovascular disease patients and utilize the multidisciplinary resources necessary to care for them.</td>
<td>DPC, AR</td>
<td>AE</td>
</tr>
<tr>
<td>2. Collaborate with other member of the health care team to assure comprehensive cardiac care.</td>
<td>DPC, AR</td>
<td>AE</td>
</tr>
<tr>
<td>3. Effective utilization of risk stratification using evidence-based medicine.</td>
<td>DPC, AR</td>
<td>AE</td>
</tr>
</tbody>
</table>
Suggested Reading


2. Murphy JG: Mayo Clinic Cardiology Review. Second Edition. Philadelphia, Lippincott Williams & Wilkins, 2000, including the following chapters:

1) Chapter 34 – Electrocardiographic Diagnosis, pages 549-597
2) Chapter 35 – Cardiac Cellular Electrophysiology, pages 597-621
3) Indications for Electrophysiologic Testing, page 621-633
4) Atrial Fibrillation, page 633-647
5) Supraventricular Tachycardia, page 647-655
6) Ventricular Tachycardia, page 655-669
7) Pacemakers, page 669-685
8) Overview of Implantable Cardioverter Defibrillators, page 685-693
9) Sudden Cardiac Death, page 693-699

The University of Kansas Medical Center Electrophysiology Research Rotation

Electrophysiology research rotation is under the supervision of an experienced faculty investigator on projects according to the institutional principles of ethics and realistic patient protection. The fellow is expected to develop skills in the following areas:

Principle teaching methods:
1. Direct clinical and research supervision by the attending electrophysiologist involved in the trial. The fellow will choose amongst an available research project or come up with an original research idea at the beginning of the 12 month block. Based on his/her pick, an attending electrophysiologist will be assigned to act as mentor
2. During the subsequent study design, medical literature, patient recruitment, study analysis, and manuscript generation, the fellow will meet regularly with his/her mentor. In addition, the fellow will work with various members of the cardiovascular research team for assistance in data collection and analysis
3. The fellow is expected to submit his/her research for a peer reviewed publication in manuscript form or as an abstract at a major national meeting
4. The fellow is expected to present his/her data to the faculty and fellow residents at KUMC.
5. The fellow will be evaluated quarterly on his research work by the EP faculty

Learning Objectives

1. Literature review to ascertain the information of a project in the area of expertise before undertaking new investigations.
2. Formulation of hypothesis with goals to ensure the hypothesis is valid and testable, that the goals are appropriate and that statistician validation is possible.
3. Submit a research protocol to the Human Subjects Committee with informed consent and patient information protection, data collection and a statistical validation of the protocol by which the investigation will be undertaken, data collection, development of analytical methods with eventual presentation of the results as an oral presentation to the Division of Cardiovascular Diseases/Mid-America Cardiology and possible submission as an abstract to the American College of Cardiology or the American Heart Association and subsequent submission to a peer-reviewed journal.
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Research time may be taken both as individual half days or days as permitted by the rotations. Fellows are expected to submit an abstract to the American College of Physicians regional meeting and eventually abstracts to a national meeting such as the American Society for Clinical Research, American College of Cardiology or American Heart Association.

Funding for expenses regarding research presentation is generally provided by the Division of Cardiovascular Diseases.

**Core Competency: Medical Knowledge**

**Goal:** Develop proficient knowledge skills and critical thinking regarding disease process, diagnosis and treatment of EP patients as it pertains to research protocols.

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate knowledge and clinical judgment attitudes and values necessary for an electrophysiologist consultant.</td>
<td>FS, KOF</td>
<td>DSP/AE EVAL</td>
</tr>
<tr>
<td>2. Demonstrate investigatory and analytic thinking approaches to various clinical arrhythmia conditions.</td>
<td>FS, KOF</td>
<td>DSP/AE EVAL</td>
</tr>
<tr>
<td>3. Assess and critically evaluate current cardiovascular medical information and scientific evidence as related to the field of Electrophysiology.</td>
<td>FS, KOF</td>
<td>DSP/AE EVAL</td>
</tr>
<tr>
<td>4. Know and apply basic science and clinical cardiac electrophysiology knowledge to patient care.</td>
<td>FS</td>
<td>AE</td>
</tr>
<tr>
<td>5. Be aware of available treatment options in cardiac electrophysiology and select the optimal therapy based on the patient’s clinical history.</td>
<td>FS, DSP, KOF</td>
<td>AE EVAL</td>
</tr>
<tr>
<td>6. Understand indications for EP procedures including device implantation and ablation for various arrhythmias.</td>
<td>FS, DSP, KOF</td>
<td>AE EVAL</td>
</tr>
<tr>
<td>7. Recognize potential complications of each EP therapy and how it might manifest itself clinically.</td>
<td>EVAL FS, DSP, KOF, IMM</td>
<td>AE EVAL</td>
</tr>
</tbody>
</table>

**Core Competency: Interpersonal and Communication Skills**

**Goal:** Demonstrate interpersonal and communication skills in medical practice that develop and maintain effective information exchange and collaboration with patients and family members as well as other professional services.

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communicate effectively with patients and families in a critical care setting.</td>
<td>FS, DPC</td>
<td>AE, SE, 360 EVAL</td>
</tr>
<tr>
<td>2. Communicate effectively with other physicians and other members of the healthcare team.</td>
<td>FS, DPC</td>
<td>AE, SE, 360 EVAL</td>
</tr>
<tr>
<td>3. Communicate effectively with colleagues to convey active patient issues.</td>
<td>FS, DPC</td>
<td>AE, 360, SE EVAL</td>
</tr>
</tbody>
</table>

**Core Competency: Professionalism**

**Goal:** Demonstrate commitment to carrying out professional responsibilities adherence to ethical principles and sensitivity to a culturally diverse patient population.

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities.</td>
<td>FS, DPC, KOF</td>
<td>AE, SE, 360EVAL</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Demonstrate a commitment to ethical principles involved in cardiac electrophysiology care or withholding care, confidentiality, or patient information, informed consent and business practice.</td>
<td>FS, PC, KOF</td>
<td>AE, 360, SE EVAL</td>
</tr>
<tr>
<td>3.</td>
<td>Demonstrate respect, compassion and integrity.</td>
<td>FS, DPC, KOF</td>
<td>AE, SE, 360EVAL</td>
</tr>
<tr>
<td>4.</td>
<td>Demonstrate responsiveness to the needs of the patients and society that supersedes self-interest.</td>
<td>FS, DPC/AE, 360, SE</td>
<td>EVAL</td>
</tr>
<tr>
<td>5.</td>
<td>Demonstrate a commitment to excellence and ongoing professional development.</td>
<td>FS, DPC</td>
<td>AE, EVAL, SE,360EVAL</td>
</tr>
</tbody>
</table>

Core Competency: Patient-Based Learning and Improvement

Goal: Learn to investigate and evaluate personal patient care practices, appraise and assimilate scientific evidence related to clinical cardiac electrophysiology and improve personal patient care practices.

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Analyze practice-based experiences and perform practice-based improvement research and activities using systematic knowledge</td>
<td>FS, AR, CCON</td>
<td>AE, SE EVAL</td>
</tr>
<tr>
<td>2. Locate, assimilate and analyze available cardiovascular evidence from scientific studies related to patients’ cardiovascular health problems.</td>
<td>FS,AR,CCON</td>
<td>AE,SE EVAL</td>
</tr>
<tr>
<td>3. Obtain and use information about their patient population and how it relates to the larger population of patients with similar arrhythmic disorders.</td>
<td>CCON, FS</td>
<td>AE, SE EVAL</td>
</tr>
<tr>
<td>4. Apply knowledge of study design, statistical methods, and patient recruitment to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.</td>
<td>CCON, FS</td>
<td>AE, SE EVAL</td>
</tr>
<tr>
<td>5. Apply knowledge from research results and data analysis to improve patient care and outcomes.</td>
<td>CCON, IMMM, FS</td>
<td>AE, SE EVAL</td>
</tr>
</tbody>
</table>

Core Competency: System-Based Practice

Goal: Demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effective call on system resources to provide care that is of optimal value to EP patients.

<table>
<thead>
<tr>
<th>Principle Educational Goals</th>
<th>Learning Activities</th>
<th>Evaluation Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understand how patient care and other professional activities affect other health care professionals, the healthcare organization and society.</td>
<td>CCON, FS</td>
<td>AE EVAL</td>
</tr>
<tr>
<td>2. Know how types of medical practice and delivery systems differ from one another including methods of controlling health care costs and allocating resources.</td>
<td>CCON</td>
<td>AE EVAL</td>
</tr>
<tr>
<td>4. Advocate for quality of cardiovascular patient care and assist patients in dealing with system complexities.</td>
<td>FS,CCON</td>
<td>AE EVAL</td>
</tr>
</tbody>
</table>

Clinical Cardiac Electrophysiology Fellow Supervision Guidelines

Levels of fellow supervision must be in compliance with these RRC program requirements. Please reference the GME Policies and Procedures Manual Section 23 for more information.

The University of Kansas School of Medicine gives fellows significant but appropriately, well-supervised latitude in the management of all patients and provides a comprehensive experience in Cardiovascular Diseases in order for
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to become independent and knowledgeable clinicians with a commitment to the life-long learning process that is critical for maintaining professional growth and competency.

During a fellow’s training, all patient care and educational activities are to be under Program Faculty supervision. Each patient must have an identifiable, appropriately-credentialed and privileged attending physician or RRC-approved licensed independent practitioner who is ultimately responsible for their care. A patient’s responsible supervising attending physician or licensed practitioner should be identified to fellows, faculty members and patients. Fellows and faculty members should inform patients of their respective roles in each patient’s care. The appropriate level of supervision depends on the individual fellow’s level of competency as determined by their knowledge, skill and attitudes. The appropriate level of Program Faculty supervision for each fellow is determined by the responsible Program Faculty, Program Director, Division Chair, and Department Chair.

Levels of fellow supervision must be in compliance with these RRC program requirements.  
Classification Levels of Supervision:  
   a. Direct Supervision: the supervision physician is physically present with the fellow and patient  
   b. Indirect Supervision with direct supervision immediately available: the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision  
   c. Indirect Supervision with direct supervision available: the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision  
   d. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

There are multiple layers of supervision of fellow educational and patient care activities, including supervision by an advanced-level fellow. Advanced-level fellow supervision is recognition of progress toward independence and demonstration of graded authority and responsibility. The final level of supervision is the responsibility of the responsible Program Faculty and Program Director. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. Faculty members functioning as supervising physicians should delegate portions of care to fellows based on the needs of the patient and the skills of the fellows. Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

<table>
<thead>
<tr>
<th>RESIDENTS IN FINAL YEARS OF TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL of SUPERVISION</strong></td>
</tr>
</tbody>
</table>
| **DIRECT** | Atrial and Ventricular stimulation  
| | Transseptal puncture  
| | RF and Cryo Ablation  
| | Device procedures:  
| | Lead placement  
| | DFT testing  
| | Lead extraction  
| | REVEAL implant/explant  
| | Elective Cardioversion and Defibrillation.  

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| INDIRECT A (with direct supervision immediately available) | Placement of diagnostic catheters
| Venous access (femoral, subclavian, IJ)
| Arterial access (femoral)
| Device procedures:
| Initial incision and make pocket
| Close incision |
| INDIRECT B (with direct supervision available) | Emergent Cardioversion and Defibrillation |
| OVERSIGHT (with direct supervision available) |

**Duty Hours**

The University of Kansas Medical Center Electrophysiology Fellowship Duty Hours and the Working Environment

Providing electrophysiology fellows with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and fellow’s well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of fellows’ time and energies. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients.

1. **Supervision of Fellows**
   a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of fellows at all times. Fellows must be provided with rapid, reliable systems for communicating with supervising faculty.
   b. Faculty schedules must be structured to provide fellows with continuous supervision and consultation.
   c. Faculty and fellows must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

**Limitations on Resident Duty Hours**
The School policy is that resident duty hours will be in compliance with the guidelines established by the Accreditation Council for Graduate Medical Education (ACGME). Each ACGME RRC may impose stricter duty hour restrictions in their program requirements. Each program’s leadership should be familiar and fully comply with these requirements.

**Exceptions to Duty Hour Policy**
The GME Leadership and the GMEC will carefully evaluate the duty hour exception request through the GMEC Major Program Change Application. The GMEC’s criteria for application approval depends upon the specific Major Program Change being requested, but generally relate to the application’s merit with regards to how the proposed change:

1. Enhances the education of the Program residents (i.e., improvement in education/service ratio, introduction of unique educational experience),
2. Does not detract from the education of surrounding ACGME-accredited core and affiliated residency programs,
3. Substantially improves compliance of a program with ACGME Program or Institutional requirements,
4. Improves resident safety and well-being (i.e., improvement in work environment) and
5. Maintains or improves the quality of patient care.

The GMEC will review the application according to the written procedures and criteria for endorsing requests for an exception to the duty hour limits delineated in the ACGME Manual on Policies and Procedures. If allowed by the
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program’s ACGME Residency Review Committee, exceptions for up to 10% or a maximum of 88 hours may be considered. The duty hour exception application will be reviewed by the GMEC prior to submission to the ACGME. Approved applications will also be monitored during the Program’s Internal Review, Site Visit Preparation process and at other intervals dependent on program and GME duty hour monitoring. Review will also be considered if other interval accreditation issues arise. The overall Review Criteria are described on the Application Tracking Form, but duty hour exception applications also include, but are not limited to:

1. Allowances specified in the ACGME Program Requirements,
2. Magnitude and PGY-level of duty hour exception requested,
3. Educational rationale for exception in terms of service/education ratio and rotations,
4. Anticipated effects on patient safety,
5. Program’s current moonlighting policy and level of moonlighting,
6. ACGME accreditation history with special regard to duty hour rule compliance,
7. Appropriateness and anticipated effectiveness of enhanced duty hour monitoring process, and
8. Program outcomes (i.e., first-attempt Board certification pass rate, disciplinary issues, scholarly activity level).

Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

ACGME requires 100% compliance with duty hour entry. Fellows will receive weekly e-mails to complete entry of duty hours.

a) Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

b) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

c) Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

d) Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time and MUST have an 8-hour time period provided between all daily duty periods for PGY-1 and intermediate-level residents. Intermediate-level residents must have 14 hours free of duty after 24 hours of in-house duty.

e) Senior-level residents will be defined by each ACGME RRC, but generally includes residents in their final years of education. It is desirable that senior-level residents have 8 hours free of duty between scheduled duty periods. Each ACGME RRC will define specific circumstances when senior-level residents may stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of duty. Circumstances of return-to-hospital activities with fewer than 8 hours away from the hospital by the senior-level residents must be monitored by the Program Director.

The resident is expected to be rested and alert during duty hours, and the resident and resident’s attending medical staff are collectively responsible for determining whether the resident is able to safely and effectively perform his/her duties.

If a scheduled duty assignment is inconsistent with the Resident Agreement or the Institutional Duty Hours and Call Policies, the involved resident shall bring that inconsistency first to the attention of the Program Director for reconciliation or correction. If the Program Director does not reconcile or correct the inconsistency, it shall be the
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obligation of the resident to notify the Department Chair or Associate Dean for Graduate Medical Education, who shall take the necessary steps to reconcile or correct the raised inconsistency.

**On-Call Activities**

The objective of on-call activities is to provide electrophysiology fellows with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when electrophysiology fellows are required to be immediately available in the assigned institution. In-house call will occur no more frequently than every third night, averaged over a four-week period. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours. Electrophysiology fellows may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements. The specific call rooms for EP fellows are HC 2900 and HC 2901 and the code for both doors is 1023*.

No new patients, as defined in Specialty and Subspecialty Program Requirements is a patient the cardiovascular fellow has not seen before, may be accepted after 24 hours of continuous duty. At-home call (pager call) is defined as call taken from outside the assigned institution. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each electrophysiology fellow. Electrophysiology fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. When electrophysiology fellows are called into the hospital from home, the hours electrophysiology fellows spend in-house are counted toward the 80-hour limit. For call taken from home (pager call), the time the electrophysiology fellow spends in the hospital after being called in is counted toward the weekly duty hour limit. The only other numeric duty hour standard that applies is that one day in seven must be free of all patient care responsibilities, which includes home call. The ACGME also requires that the Electrophysiology Fellowship program monitor the intensity and workload resulting from home call, through periodic assessment of the frequency of being called into the hospital and the length and intensity of the in-house activities.

"The 10-Hour-Break and the 24+4 standard will not be applied to Home Call. The program director will monitor the demands of home-call rotations, and make the necessary adjustments to avoid excessive service. However, if electrophysiology fellows on "home call" were so busy that they were forced to remain in the hospital the majority of nights, then "home call" would be viewed as in-house call and all the usual duty hour standards would then apply.

Otherwise, if a fellow on home-call after leaving the hospital at 6:00 PM, he/ she may return at 2:00 AM to perform a procedure. Assuming the fellow returns home after the procedure, he/ she may return to the hospital at the usual time the following morning without regard for the 10-hour break. The 10-hour break applies to scheduled daily duty periods and after in-house call.

Back-up support systems are provided within patient care when responsibilities are unusually difficult or prolonged, or if unexpected circumstances create electrophysiology fellow fatigue sufficient to jeopardize patient care.

**Hand Off Policy**

The Division of cardiac electrophysiology provides a consultative service to inpatients at KU Medical Center for which residents are an integral part clinical care. In addition, the EP service cares for their post procedure patients. Therefore, communication regarding patient care is important. Every morning during the week, a discussion of all the patients on the service as well as consultative services occurs with the CCEP fellows, rounding residents, attending staff, and nurse practitioners. Each patient is reviewed in detail and a plan is made for the day. At the conclusion of the day, the attending staff meets with the nurse practitioner and fellow who are on call overnight to review the patients again and plans for the following day. Written sign out occurs Friday evening in preparation for weekend rounding.
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Moonlighting

The ability to moonlight with departmental sanction is regulated by the Program Director. The University of Kansas Medical Center is an approved site for moonlighting. Additional site requests must be submitted in writing to the Program Director for approval.

Fellows will request approval for moonlighting via the moonlighting request in MedHub. Upon approval of moonlighting, fellows will enter moonlighting hours in MedHub each week.

Moonlighting is not a right, it is a privilege. Electrophysiology fellows must be in good standing and progressing steadily through the Department to be sanctioned to moonlight.

Moonlighting must not conflict with training assignment, call schedule, or patient responsibilities. In order to participate in moonlighting, electrophysiology fellows must read and sign the moonlighting packet provided by GME and the department. All moonlighting hours are counted toward weekly work hours, which must not exceed 80 hours total.

In addition, all duty hour requirements regarding residency may apply to moonlighting as well, and must not be violated. Electrophysiology fellows cannot moonlight if doing so brings them into conflict with duty hour requirements while performing their normal duties. Electrophysiology fellows with J-1 or H-1B visas are eligible to moonlight.

Evaluations

Electrophysiology Fellow Evaluation

The Electrophysiology program has an effective plan for assessing electrophysiology fellow performance throughout the program and for utilizing the results to improve electrophysiology fellow performance.

This plan includes the use of methods that produce an accurate assessment of electrophysiology fellows’ competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice and mechanisms for providing regular and timely performance.

Feedback to electrophysiology fellows includes a quarterly evaluation that is communicated to each electrophysiology fellow in a timely manner and the maintenance of a record of evaluation for each electrophysiology fellow that is accessible to the fellow. The Program Director and the Evaluation Committee in the Division of Cardiovascular Diseases and Mid-America Cardiology assess results to achieve progressive improvements in electrophysiology fellows’ competence and performance. Sources of evaluation include faculty, patients, peers, self, and other professional staff. The program director and the Evaluation Committee will provide a final evaluation for each electrophysiology fellow who completes the program. The evaluation includes a review of the electrophysiology fellow’s performance during the final period of education and verifies that the electrophysiology fellow has demonstrated sufficient professional ability to practice competently and independently. The final evaluation will be part of the electrophysiology fellow’s permanent record maintained by the University of Kansas Electrophysiology Fellowship Program.

Faculty Evaluation

The performance of the faculty will be evaluated by the program no less frequently than at the midpoint of the accreditation cycle and again prior to the next site visit. The evaluations should include a review of their teaching
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abilities, commitment to the educational program, clinical knowledge, and scholarly activities. Annual written confidential evaluations by electrophysiology fellows will be included in this process.

Program Evaluation

The educational effectiveness of the Electrophysiology Fellowship Program will be evaluated at least annually in a systematic manner. Representative program personnel, i.e., the program director, representative faculty, and at least one electrophysiology fellow, must be organized to review program goals and objectives and the effectiveness of the program in achieving them. The group will have quarterly documented meetings at least for this purpose.

In the evaluation process, the group will take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution (see Institutional Requirements I.B.3.d), and the electrophysiology fellows’ confidential written evaluations. If deficiencies are found, the group will prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes.

Outcome Assessment

The Program Director and the Evaluation Committee uses fellow performance and outcome assessment in its evaluation of the educational effectiveness of the Electrophysiology Fellowship Program. The Committee uses electrophysiology fellow and performance assessment results together with other program evaluation results to improve the Electrophysiology Fellowship Program. Performance of program graduates on the certification examination will be used as one measure of evaluating program effectiveness.

Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects supported by sound educational principles are encouraged.

Requests for experimentation or innovative projects that may deviate from the program requirements must be RRC prior-approved and must include the educational rationale and a method for evaluating the project.

The University of Kansas Medical Center and Electrophysiology Fellowship Program are jointly responsible for the quality of education offered to electrophysiology fellows for the duration of such a project.

Medical Administration Services of KU Med
Proper Dress and Grooming

We project an image of professionalism in our community. The grooming and dress of our employees conveys a message of respect, credibility, and quality of service. In a health care setting, appearance and cleanliness are extremely important in meeting the standards for infection control and safety. Employees have the opportunity to create a positive impression by consistently presenting themselves as models of cleanliness, modesty and conservative good taste.

The following standards should be practiced consistently:

Grooming Standards

• Practice daily oral hygiene
• Bathe daily and use effective deodorant
• Heavily scented toiletries should be avoided
• Fingernails should be clean, well-groomed, and of a reasonable length
• Make-up should be conservative and in good taste
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• Hair styles as well as mustaches and beards should be clean, neatly groomed, and moderate
• Use of jewelry should be minimal and conservative
• Fingernails should be clean, well groomed and of a reasonable length. Due to infection control issues, employees who are providing direct patient care may not wear artificial fingernails or extenders and must keep fingernails trimmed to ¼ inch above each finger in keeping with APIC standards.** This policy may apply to other positions in the Hospital as determined by the Vice President of the department.

** According to the Association for Professionals in Infection Control (APIC) artificial nails or extenders have been found to harbor pathogenic organisms and have been implicated in the transmission of organisms to patients.

Clothing Standards

• All garments must be fresh and clean
• Uniforms: as designated by respective department
• Shoe soles should be non-marking and without metal caps
• Socks or hose must be worn
• Appropriate undergarments must be worn

Unacceptable Clothing

• Athletic shoes and t-shirts are generally not acceptable except as designated specifically by department uniform code
• Tight fitting or revealing garments
• Blue jeans, sweat clothing, shorts, halter-tops, leggings, mini-skirts
• Items of clothing imprinted with advertising or objectionable language

The preceding standards are not all inclusive. Each department manager has the option to implement specific additional guidelines within the framework of this policy. If there is a question as to the appropriateness of a particular item, it should not be worn without consulting the immediate supervisor.

An employee may be asked to return home to change clothing on his/her own time. Failure to follow standards may result in disciplinary action up to and including termination.

Eating and Drinking in Patient Care Areas
Infection Control

Food and Drinks in Patient Care Areas and at Nurse’s Stations

Many of you have undoubtedly heard that hospital employees, residents, attendees, medical students and other patient care providers are not allowed to consume food or drink anything near or in areas immediately adjacent to, in, or surrounding patient care areas. This rule also includes the nurse’s stations. Lately, inspections on various patient floors by the Infection Control Nursing personnel have turned up numerous violations and it appears many are ignoring this Federal rule. We are asking everyone to abide by this Federal rule and not consume food or drink liquids in patient care areas.

• Why do we enforce this rule? And,
• Why is this a concern?
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**We enforce this rule because it is the law.**

The Occupational Safety & Health Administration (OSHA), a governmental agency whose purpose is to make sure employees have a safe environment and workplace, prohibits employees and patient care providers from consuming food and drinking of liquids in patient care areas of a hospital. This protects all patients and employees from the remote possibility that food or drink can be contaminated from infectious materials or hazardous chemicals.

- This is not a new requirement.
- It became law in 1992.

**The Hospital enforces this rule because it makes sense.**

In 1993, there was an outbreak of Hepatitis A on a nursing unit in a hospital in Iowa. Hepatitis A was transmitted to eleven healthcare workers, with secondary spread to 1 patient and the fiancé of one of the nurses. The investigators conducted a case-control study to determine what factors contributed to the spread of this infection. The results indicated that in this outbreak, **the single most important risk factor for developing Hepatitis A infection was eating and drinking on the patient care unit.**¹

Nurse’s stations are covered with germs from patient charts and the hands of different healthcare workers and others; germs such as VRE, MRSA, C. difficile, and even Hepatitis A. When you eat or drink on the patient care floors, you may be ingesting any one or more of these germs. And, as demonstrated by the study described above, you can share these organisms with other patients, your friends and even your family.

Please help us in complying with OSHA, JCAHO and KDHE requirements by eating and drinking only in authorized locations - the nurse’s lounge or Hospital cafeteria. If you have any questions, please contact the Infection Control Office @ ext. 8-2779.


**PhRMA Code on Interactions with Healthcare Professionals**

**Preamble**

*The Pharmaceutical Research and Manufacturers of America (PhRMA) represents research-based pharmaceutical and biotechnology companies. Our members develop and market new medicines to enable patients to live longer and healthier lives.*

*Ethical relationships with healthcare professionals are critical to our mission of helping patients by developing and marketing new medicines. An important part of achieving this mission is ensuring that healthcare professionals have the latest, most accurate information available regarding prescription medicines, which play an ever-increasing role in patient healthcare. This document focuses on our interactions with healthcare professionals that relate to the marketing of our products.*

*Effective marketing of medicines ensures that patients have access to the products they need and that the products are used correctly for maximum patient benefit. Our relationships with healthcare professionals are critical to achieving these goals because they enable us to—*

- *inform healthcare professionals about the benefits and risks of our products,*
- *provide scientific and educational information,*
- *support medical research and education,* and
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• obtain feedback and advice about our products through consultation with medical experts.

In interacting with the medical community, we are committed to following the highest ethical standards as well as all legal requirements. We are also concerned that our interactions with healthcare professionals not be perceived as inappropriate by patients or the public at large.

This Code is to reinforce our intention that our interactions with healthcare professionals are to benefit patients and to enhance the practice of medicine. The Code is based on the principle that a healthcare professional’s care of patients should be based, and should be perceived as being based, solely on each patient’s medical needs and the healthcare professional’s medical knowledge and experience.

Therefore, PhRMA adopts, effective July 1, 2002, the following voluntary Code on relationships with healthcare professionals. This Code addresses interactions with respect to marketed products and related pre-launch activities. It does not address relationships with clinical investigators relating to pre-approval studies.

PhRMA Code on Interactions with Healthcare Professionals

1. BASIS OF INTERACTIONS
Our relationships with healthcare professionals are intended to benefit patients and to enhance the practice of medicine. Interactions should be focused on informing healthcare professionals about products, providing scientific and educational information, and supporting medical research and education.

2. INFORMATIONAL PRESENTATIONS BY OR ON BEHALF OF A PHARMACEUTICAL COMPANY
Informational presentations and discussions by industry representatives and others speaking on behalf of a company provide valuable scientific and educational benefits. In connection with such presentations or discussions, occasional meals (but no entertainment/recreational events) may be offered so long as they: (a) are modest as judged by local standards; and (b) occur in a venue and manner conducive to informational communication and provide scientific or educational value. Inclusion of a healthcare professional’s spouse or other guests is not appropriate. Offering “take-out” meals or meals to be eaten without a company representative being present (such as “dine & dash” programs) is not appropriate.

3. THIRD-PARTY EDUCATIONAL OR PROFESSIONAL MEETINGS
   a. Continuing medical education (CME) or other third-party scientific and educational conferences or professional meetings can contribute to the improvement of patient care and therefore, financial support from companies is permissible. Since the giving of any subsidy directly to a healthcare professional by a company may be viewed as an inappropriate cash gift, any financial support should be given to the conference’s sponsor, which, in turn, can use the money to reduce the overall conference registration fee for all attendees. In addition, when companies underwrite medical conferences or meetings other than their own, responsibility for and control over the selection of content, faculty, educational methods, materials, and venue belongs to the organizers of the conferences or meetings in accordance with their guidelines.

   b. Financial support should not be offered for the costs of travel, lodging, or other personal expenses of non-faculty healthcare professionals attending CME or other third-party scientific or educational conferences or professional meetings, either directly to the individuals attending the conference or indirectly to the conference’s sponsor (except as set out in section 6 below). Similarly, funding should not be offered to compensate for the time spent by healthcare professionals attending the conference or meeting.

   c. Financial support for meals or receptions may be provided to the CME sponsors who in turn can provide meals or receptions for all attendees. A company also may provide meals or receptions directly at such events if it complies with the sponsoring organization’s guidelines. In either of the above situations, the meals or receptions should be modest and be conducive to discussion among faculty and attendees, and the amount of time at the meals or receptions should be clearly subordinate to the amount of time spent at the educational activities of the meeting.
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d. A conference or meeting shall mean any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentations(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented.

4. CONSULTANTS  
a. It is appropriate for consultants, who provide services, to be offered reasonable compensation for those services and to be offered reimbursement for reasonable travel, lodging, and meal expenses incurred as part of providing those services. Compensation and reimbursement that would be inappropriate in other contexts can be acceptable for bona fide consultants in connection with their consulting arrangements. Token consulting or advisory arrangements should not be used to justify compensating healthcare professionals for their time or their travel, lodging, and other out-of-pocket expenses. The following factors support the existence of a bona fide consulting arrangement (not all factors may be relevant to any particular arrangement):

- a written contract specifies the nature of the services to be provided and the basis for payment of those services;
- a legitimate need for the services has been clearly identified in advance of requesting the services and entering into arrangements with the prospective consultants;
- the criteria for selecting consultants are directly related to the identified purpose and the persons responsible for selecting the consultants have the expertise necessary to evaluate whether the particular healthcare professionals meet those criteria;
- the number of healthcare professionals retained is not greater than the number reasonably necessary to achieve the identified purpose;
- the retaining company maintains records concerning and makes appropriate use of the services provided by consultants;
- the venue and circumstances of any meeting with consultants are conducive to the consulting services and activities related to the services are the primary focus of the meeting, and any social or entertainment events are clearly subordinate in terms of time and emphasis.

b. It is not appropriate to pay honoraria or travel or lodging expenses to non-faculty and non-consultant attendees at company-sponsored meetings including attendees who participate in interactive sessions.

5. SPEAKER TRAINING MEETINGS  
It is appropriate for healthcare professionals who participate in programs intended to recruit and train speakers for company sponsored speaker bureaus to be offered reasonable compensation for their time, considering the value of the type of services provided, and to be offered reimbursement for reasonable travel, lodging, and meal expenses, when (1) the participants receive extensive training on the company’s drug products and on compliance with FDA regulatory requirements for communications about such products, (2) this training will result in the participants providing a valuable service to the company, and (3) the participants meet the criteria for consultants (as discussed in part 4.a. above).

6. SCHOLARSHIPS AND EDUCATIONAL FUNDS  
Financial assistance for scholarships or other educational funds to permit medical students, residents, fellows, and other healthcare professionals in training to attend carefully selected educational conferences may be offered so long as the selection of individuals who will receive the funds is made by the academic or training institution.
“Carefully selected educational conferences” are generally defined as the major educational, scientific, or policy-making meetings of national, regional, or specialty medical associations.

7. EDUCATIONAL AND PRACTICE-RELATED ITEMS
   a. Items primarily for the benefit of patients may be offered to healthcare professionals if they are not of substantial value ($100 or less). For example, an anatomical model for use in an examination room primarily involves a patient benefit, whereas a VCR or CD player does not. Items should not be offered on more than an occasional basis, even if each individual item is appropriate. Providing product samples for patient use in accordance with the Prescription Drug Marketing Act is acceptable.

   b. Items of minimal value may be offered if they are primarily associated with a healthcare professional’s practice (such as pens, notepads, and similar “reminder” items with company or product logos).

   c. Items intended for the personal benefit of healthcare professionals (such as floral arrangements, artwork, music CDs or tickets to a sporting event) should not be offered.

   d. Payments in cash or cash equivalents (such as gift certificates) should not be offered to healthcare professionals either directly or indirectly, except as compensation for bona fide services (as described in parts 4 and 5). Cash or equivalent payments of any kind create a potential appearance of impropriety or conflict of interest.

8. INDEPENDENCE OF DECISION MAKING
   No grants, scholarships, subsidies, support, consulting contracts, or educational or practice related items should be provided or offered to a healthcare professional in exchange for prescribing products or for a commitment to continue prescribing products.
   Nothing should be offered or provided in a manner or on conditions that would interfere with the independence of a healthcare professional’s prescribing practices.

9. ADHERENCE TO CODE
   Each member company is strongly encouraged to adopt procedures to assure adherence to this Code.

Frequently Asked Questions

a. Question
   Under the Code, may items such as stethoscopes be offered to healthcare professionals?

   Answer
   Yes, because these items primarily benefit patients, so long as the items are not of substantial value and are only occasionally offered to the healthcare professional. Items that are of more than minimal value and do not primarily benefit patients are also not permitted even if they bear a company or product name.

b. Question
   Under the Code, may golf balls and sports bags be provided if they bear a company or product name?

   Answer
   No. Golf balls and sports bags, even if of minimal value, do not primarily entail a benefit to patients and are not primarily associated with the healthcare professional’s practice, even if they bear the name of a company or product.
c. Question

Under the Code, may healthcare professionals be provided with gasoline for their cars if they are provided with product information at the same time?

**Answer**

No. Items intended for the personal benefit of a healthcare professional should not be offered.

d. Question

The Code says that informational presentations and discussions may be accompanied by occasional, modest meals. What types of presentations and meals would this include?

**Answer**

An informational presentation or discussion may be accompanied by a modest meal provided that the venue and manner of presentation/discussion is conducive to a scientific or educational interchange. For example, if a medical or scientific expert (who is a consultant to or employee of the company) is providing information about recently obtained study data to an audience of healthcare professionals, this could be done over lunch or dinner at a quiet restaurant providing the meal was of modest value as judged by local standards. Following the same logic, if a sales representative is providing substantial scientific or educational information regarding a company’s products to one or a few healthcare practitioners, this could also be done during a modest meal which could be at or outside of a physician’s office. However, if the nature or location of the meal would not facilitate communication of the information, then a meal would not be appropriate. Further, the use of modest meals on more than an occasional basis would not be appropriate.

e. Question

A representative of Company X provides pizza for the staff of a medical office. Is this consistent with the Code?

**Answer**

This would be consistent with the Code if the representative will provide an informational presentation to the medical staff in conjunction with the meal of modest value, so long as the location of the presentation is conducive to a scientific or educational communication. Merely dropping off food for the office staff, however, would not be consistent with the Code.

f. Question

A representative of Company X invites physicians to meet to hear a scientific and educational presentation about a new drug at the café at a nearby bookstore. Coffee and cake are provided by the representative and, following the presentation (which is in small groups), each physician is given a gift certificate for books in the amount of $30. Does this conform to the Code?

**Answer**

No. While the presentation may present scientific or educational information and the coffee and cake may appropriately be provided, an open-ended gift certificate is a cash equivalent. A medical textbook, a book on patient care, or a gift certificate redeemable solely for a medical textbook or book on patient care could be provided if it is not of substantial value.
Company C invites 30 physicians to a corporate suite at a professional baseball game for a 45-minute scientific and educational presentation followed by a buffet and the three-hour game. Does this conform to the Code?

Answer
No. A modest buffet meal accompanying a scientific or educational would be acceptable. However, the provision of entertainment and/or recreational activities, including entertainment at sporting events in connection with an educational or scientific presentation or discussion, is inconsistent with the Code.

h. Question
Under what circumstances would the Code permit a company to provide entertainment or recreational activities directly to healthcare practitioners?

Answer
Companies may provide modest entertainment or recreational activities to healthcare practitioners in a context where those practitioners are providing a legitimate service to the companies, such as when they act as bona fide consultants on an advisory board or are trained at a speaker-training meeting. Companies should generally not provide entertainment or recreational activities to healthcare practitioners. Thus, companies should not invite healthcare professionals to sporting events, concerts, or shows, or provide them with recreational activities such as hunting, fishing, boating, ski trips, or golf outings, even if those entertainment events or recreational activities are used to facilitate informational interchanges between the company representative and the healthcare professional. Similarly, it would be inappropriate to provide these types of entertainment and recreational events in conjunction with promotional scientific presentations by medical experts.

i. Question
Company A retains a small group of 15 nationally known physicians regarding a therapeutic area relevant to company A’s products to advise on general medical and business issues and provide guidance on product development and research programs for those products. These physicians are paid significant fees, but those fees are typical of the fees paid to thought leaders in this therapeutic area. They normally meet once or twice a year at resort locations to discuss the latest product data, research programs and Company plans for the product(s). Does this comply with the Code? If it does, is it appropriate to pay for the spouse of the healthcare professional to attend, as well?

Answer
This arrangement appears to comply with the Code. The number of advisors seems reasonably small. The advisors seem to have been selected based on their expertise in the areas where advice is needed. While the consultants are paid significant fees, these appear to be reasonable under the circumstances. Finally, while holding consultant meetings at resort locations is not prohibited, the facilities chosen should be conducive to the services provided as well as reasonable and appropriate to the conduct of the meeting. It would not be appropriate to pay for the cost of the spouse of the advisor. If the spouse attends, it should be at the cost of the advisor.

j. Question
Company A invites 300 physicians/consultants to a two-day and one-night speaker training program at a regional golf resort. All attendees are compensated for their participation and their expenses are reimbursed. Prospective speakers are selected based on recommendations of the Company’s district managers and an assessment of their qualifications by the Company’s medical or scientific personnel. Each of the attendees is required to sign an
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agreement in advance covering the services they will provide. They are educated by a faculty on the full range of data surrounding the disease state and the Company’s drug product, on presentation skills, and on FDA regulatory requirements. The Company plans to use at least 280 participants as speakers over the coming year, and it needs to train 300 speakers in order to ensure that 280 will actually be available when needed. Training sessions take both days, and the Company provides for a few hours of golf and meals. Does this program conform to the Code? If so, is it appropriate to pay for a spouse of the healthcare professional, as well?

**Answer**

This arrangement appears to comply with the Code. Speaker training is an essential activity because FDA holds companies accountable for the presentations of their speakers. In this case, the participants undergo extensive training that will result in a valuable service being provided to the company, and the arrangement meets reasonable indicia of a bona fide consulting relationship. While resort locations are not prohibited, the Company may want to consider whether it would be more appropriate to hold the training session at a non-resort location. In this case, the number of speakers being trained is important; if significantly more participants were trained than were to be used as speakers, this arrangement would not comply with the Code. The amount of time spent training speakers should be reasonable in relation to the material that has to be covered.

The compensation offered to prospective speakers, including the value of any entertainment, should be evaluated to assure that it is reasonable compensation for that time. It would not be appropriate to pay for the cost of the spouse of the healthcare professional. If the spouse attends, it should be at the cost of the healthcare professional.

**k. Question**

A sales representative invites a physician out for a round of golf and lunch following the golf. The physician is very busy and is difficult to see in her office. The cost of the golf and the lunch combined are $65. Does this comply with the code?

**Answer**

No. It is inconsistent with the Code to provide entertainment or recreational activities such as golf.

**Vacation**

The University will provide up to maximum of three weeks (15 workdays) of vacation per year, which is covered by the resident stipend.

Vacation cannot be accumulated from year to year.

Vacation must be requested from and approved by the Program Director or a designee in advance in the manner prescribed by the program.

Denial of a specific request for vacation is a management decision on the part of the officers of the program and is not a grievable matter under these policies and procedures.

**Sick Leave**

The University will provide up to 10 workdays of sick leave per year to cover personal illness or illness in the resident’s immediate family (spouse or children).

Sick leave cannot be accumulated from year to year.

The use of sick leave must be approved by the Program Director or Department Chair.
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At the discretion of the Chair or Program Director, a physician’s written statement may be required as a condition of approval for sick leave.

**Personal Leave**

A resident may request up to three months (12 weeks) of leave without pay per year for reasons of illness, serious health condition, disability of the resident or in the resident’s immediate family, or the birth or adoption of a child. The decision to grant such leave is at the discretion of the officers of the program, but denial of a request for leave is a grievable matter.

Leave for birth or adoption cannot be taken intermittently. If both spouses are members of the resident staff, their combined total leave for birth or adoption is limited to three months per year; and if less than the maximum three months is taken for birth or adoption, the balance can be used for reasons of illness or other serious health condition.

a) “Immediate family” is defined as a child, parent, or spouse of the resident related by blood, marriage, or adoption.

b) “Serious health condition” is defined as an illness, injury, impairment or any physical or mental condition that requires inpatient medical care or continuing treatment by a health care provider.

Stipend payments to the resident will be suspended during periods of leave without pay, but the resident will continue to receive all other benefits. There is a cost to continue health insurance. In lieu of having the stipend payments interrupted, the resident can elect to use a portion of the allotted vacation time instead of leave without pay.

If the maximum number of vacation and sick leave days for the year has been used, the resident must request leave without pay.

When possible, the resident must give the School and program 30 day notice of the intent to take leave for foreseeable events such as childbirth, adoption, or necessary medical procedures. However, if the birth, adoption, or medical treatment requires leave to begin in less than 30 days, the resident must provide notice as soon as reasonably possible.

The use of leave without pay may require the resident to extend his/her training program to satisfy the duration of training board eligibility/certification requirements (see [http://gme.kumc.edu/EligibilityforSpecialtyBoardExams.xlsx](http://gme.kumc.edu/EligibilityforSpecialtyBoardExams.xlsx) for information related to specialty board exams). The length of the extension, if required, will be equal to the total time absent from the program, excluding vacation leave and sick leave. A resident satisfying an obligatory training extension due to leave without pay will receive a stipend and other benefits subject to the usual terms of the Agreement that covers the extended training period.

**Leave of Absence**

A resident, who has used the maximum amount of personal leave, but still requires relief from the responsibilities of the program, may request a leave of absence.

At the program’s discretion and in accordance with the rules of the particular RRC and/or specialty board, the leave of absence, if granted, may extend to the termination date of the existing resident agreement.

All stipend payments and benefits will be suspended during a leave of absence.
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Residents seeking to return from a leave of absence must reapply to the program and they are not assured of a position.

Training Extension

The use of personal leaves or leaves of absence from the program may require the resident to extend his/her training program to satisfy the duration of training board eligibility/certification requirements.

The length of the extension, if required, will be equal to the total time absent from the program, excluding vacation.

The resident will sign a resident agreement to cover the extension period.

A resident satisfying an obligatory training extension due to the use of personal leave will receive a stipend and other benefits subject to the usual terms of the Agreement that covers the extended training period.

Holidays

Holiday definitions differ between Mid-America Cardiology, the University of Kansas and the KU Hospital Authority. For Cardiology 7:00 conferences and the fellow on call that day these dates are considered holidays.

- New Year’s Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day (Not a KU Holiday.)
- Veteran’s Day (Not a KU Holiday.)
- Thanksgiving Day (2 days) (The day after Thanksgiving is NOT a VA Holiday.)
- Christmas Day

Military Leave

Active Duty. A Resident, who enlists or is drafted into the armed forces of the United States, including reservists and members of the National Guard who are activated to military duty, other than active duty for training purposes, shall be granted military leave without pay.

Active Duty for Training Purposes. A Resident who is a member of the State Guard or Kansas National Guard or the reserves of the United States Armed Forces shall be granted a maximum of 12 working days per calendar year of military leave with pay for active duty for training purposes. Any active duty for training purposes in excess of 12 workings days in a calendar year shall be charged to military leave without pay, or at the Resident’s request, to accrued vacation leave.

Emergency Duty. A Resident who is a member of the State Guard or Kansas National Guard shall be granted military leave with pay for the duration of any official call to state emergency duty.

Other Accruals. Sick leave, vacation leave, and holidays shall not be earned or accrued during a period of military leave without pay.

Notice. When a Resident is called for duty, the Resident should be sustained during such duty, and the Resident shall be permitted to return to the program in a similar position with status and pay like that which the Resident occupied at the time of the beginning of the military leave.
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Credit for Service. Unless otherwise specified in the applicable program regulations and agreed to by the program director, the time away for military leave does not count toward the Resident’s time in the program.

Release from Duty. The Resident should contact the program director within 30 days of the Resident’s release from duty. The Resident and the program director should agree on the date of the next regular working period that the Resident would be required to work; provided that such date is no later than ninety (90) days following the Resident’s release from duty.

Professional Leave

The University of Kansas will provide all residents with paid professional leave at the discretion of the Program Director for the following reasons:

a) While in the due process phase of a fair hearing or if relieved of clinical and patient care duties for reasons of suspension or probation.

b) Scholarly presentations at national or regional conferences

c) Conference attendance in a community away from the University of Kansas Medical Center

d) Studying for medical board examinations

e) Taking medical board examinations

Scientific Meetings

Cardiovascular fellows are permitted up to 5 days per academic year to attend scientific meetings such as American Heart, American College of Cardiology, American Society of Echocardiography as well as Kansas Regional American College of Physicians meetings.

Professionalism

1. Adhere to basic ethical principles
   a. Document and report clinical information truthfully
   b. Follow formal policies
   c. Accept personal errors and honestly acknowledge them
   d. Uphold ethical expectations of research and scholarly activity
   e. Come to work fit, rested and ready to work

2. Demonstrate compassion and respect to patients
   a. Demonstrate empathy and compassion to all patients
   b. Demonstrate a commitment to relieve pain and suffering
   c. Provide support (physical, psychological, social and spiritual) for dying patients and their families
   d. Provide leadership for a team that respects patient dignity and autonomy

3. Provide timely, constructive feedback to colleagues
   a. Communicate constructive feedback to other members of the health care team
   b. Recognize, respond to and report impairment in colleagues or substandard care via peer review process
4. Maintain Accessibility
   a. Responsibilities including but not limited to calls and pages
   b. Carry out timely interactions with colleagues, patients and their designated caregivers

5. Recognize conflicts of interest
   a. Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients
   b. Maintain ethical relationships with industry
   c. Recognize and manage subtler conflicts of interest

6. Demonstrate personal accountability
   a. Dress and behave appropriately
   b. Maintain appropriate professional relationships with patients, families and staff
   c. Ensure prompt completion of clinical, administrative, and curricular tasks
   d. Recognize and address personal, psychological, and physical limitations that may affect professional performance
   e. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately
   f. Serve as a professional role model for more junior colleagues (e.g., medical students, interns)
   g. Recognize the need to assist colleagues in the provision of duties

7. Practice individual patient advocacy
   a. Recognize when it is necessary to advocate for individual patient needs
   b. Effectively advocate for individual patient needs

8. Comply with public health policies
   a. Recognize and take responsibility for situations where public health supersedes individual health (e.g., reportable infectious diseases)

9. Respect the dignity, culture, beliefs, values and opinions of the patient
   a. Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age or socioeconomic status
   b. Recognize and manage conflict when patient values differ physician’s values

10. Confidentiality
    a. Maintain patient confidentiality
    b. Educate and hold others accountable for patient confidentiality

11. Recognize and address disparities in health care
    a. Recognize that disparities exist in health care among populations and that they may impact care of the patient
    b. Embrace physicians’ role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering
    c. Advocates for appropriate allocation of limited health care resources.

Resident Case Log System:

The CCEP fellows are responsible for keeping a detailed record of cases completed. This will include patient name, DOB, procedure performed, attending physician, and complications incurred. Currently the information is kept in a secure database within the EP department. However, plans are being made to transition the database to MedHub. The fellows are aware of the minimum number of procedures performed in order to sit for CCEP boards. Their
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progress toward this minimum number is discussed with the resident each evaluation period and strategies to increase their exposure to certain procedures are also reviewed.

Impairment

Satisfactory performance includes the absence of significant impairment (impaired function of a fellow to a degree that it is causing less than satisfactory performance, and/or the impaired function, if not corrected or is uncorrectable, is likely to lead to future unsatisfactory performance) due to physical, mental, or emotional illness, personality disorder, or substance abuse. Every effort will be made to reasonably accommodate those individuals with conditions or impairments that qualify as a disability under applicable law, provided that the accommodation does not present an undue hardship for the Department, the Medical School, or The University of Kansas Medical Center Cardiovascular Diseases Fellowship Education and Training 129 venues of training. Fellows will nevertheless be required to satisfactorily meet the Division’s performance criteria, requirements, and expectations of the Cardiovascular Diseases Fellowship Program. Please refer to Kansas University Medical Center’s Graduate Medical Education Policy Manual for the details of institutional policy regarding identification of impairment, reintegration into training, and ongoing monitoring of affected fellows.

GME Fatigue (Transportation/Swing Room) Guidelines

• If you are fatigued and unable to perform your patient care duties, please contact your supervisor (i.e., chief resident, faculty supervisor, program director, Chair and/or GME Office/DIO). Please inform your supervisor of your situation so that they can arrange for alternate coverage to ensure continuity of patient care.

• Program call rooms should be utilized for fatigued residents/fellows for rest and/or power napping.

• If your program does not have a call room or if your assigned call rooms are unavailable or in use, you may use the swing call room – (HH room 2901 (code 4040*)

• If adequate rest facilities are not available, then you may use the voucher fatigue transportation service

• The program leadership and administration will receive 2 vouchers for every 10 residents. (Attached) The PC should keep this in a place well known to the residents for easy access afterhours.

• For each event 2 vouchers will be needed (one for home and then one for back to work the following morning)

• The Vouchers will need to be filled in by the resident/fellow and the transportation service driver (designated as KUMC Resident Program Transportation voucher). Please print your name, Department and home address on the voucher.

• When you are ready to leave, please call 10/10 Taxi Service (913-647-0010) and tell them you are using the KUMC Resident Program Transportation voucher and your destination. They will pick you up at the Main Entrance of the hospital.

• The transportation service will collect each voucher white copy and submit to the GME Office. It is important that you return the YELLOW copy of the voucher to your program director.

• The transportation service is allowed to pick you up from the KUH Hospital Main Entrance and drop you off at your home address, without any interval stops. This also applies for the return trip from your home to back to the hospital main entrance the next morning. You need to use the second voucher for the return trip.
The resident is responsible for discussing the event and fatigue issue with their Program Leadership the following day. This must be documented by the program leadership in the “Fatigue/Transportation Incident Report.” This is available in MedHub – Fatigue/Transportation Incident Report (example below). Again, please return the yellow voucher copies to your program director at this time as well. The purpose of this file is to track both individual and program-wide episodes of fatigue and additional duty in order to mitigate future recurrences.

• The GME Office will manage the cab vouchers and bill back the departments as they are being used as well as replenish the voucher supply.

Sample KUMC Resident Program Transportation voucher:
The University of Kansas Medical Center
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Fatigue/Transportation Incident Report

(Question 1 of 4 - Mandatory)

Date of the Transportation incident:

Rotation Name/Location  (Question 2 of 4 - Mandatory)

Fatigue Situation Circumstances:  (Question 3 of 4 - Mandatory)

Actions to mitigate fatigue are as follows:  (Question 4 of 4 - Mandatory)

Grievance

Please refer to the GME Policies and Procedures Manual section 13 for more information.

A grievance procedure is available to fellows for resolution of problems relating to their appointments or responsibilities, including differences with the School, Program, or any representative thereof. The School ensures the availability of procedures for redress of grievances, including complaints of discrimination and sexual harassment, in a manner consistent with the law and with the general policies and procedures of the University of Kansas and the School. The grievance process is available to all fellows in the programs sponsored by the School of Medicine.

Deficiency and Remediation

Please refer to the GME Policies and Procedures Manual section 4, for a comprehensive section on deficiency and remediation policies.

Remediation is the process in which the faculty of a Program and a fellow judged to be performing at a less than satisfactory level work together to identify, understand, and correct the cause(s) for the fellow’s deficiencies.

Probation identifies a fellow as requiring more intensive levels of supervision, counseling and/or direction than is required of other fellows at the same training level in the same program.

Disciplinary Actions

Should a fellow be found to be deficient in any of the criteria or parameters of performance and not meet advancement or promotion specifics, he/she will meet with the Program Director, wherein 1) The expectations and deficiencies will be stated, 2) What the individual can do to improve will be explored and planned, and 3) An attempt will be made to determine if there are outside factors which may explain why a problem has developed. At this point a determination will be made of whether the fellow is in good standing or is in a Performance Warning Status (PWS). Isolated unsatisfactory marks during the 8 to 12 months of the academic year (and particularly following a probationary period), may be asked to repeat the year.

The Program extends many professional courtesies to its fellows and asks that fellows be professional and alert the Program Director well in advance of his/her intended date of departure. Similarly, the Program reserves the right not to renew a contract for any fellow it deems as performing in an unsatisfactory manner.
Resident Assistance and Access to Counseling

The University of Kansas Medical Center is interested in the health and wellbeing of its residents. At some time, members of the resident staff may be faced with a variety of personal problems that may affect their wellness and job. The PWS will involve a period of 3 months, where the performance of the fellow can be monitored more closely. PWS is designed to identify weaknesses that, if not remedied, may lead to probation or dismissal. The Program Director will be responsible for determining the process for remediation. This meeting will be documented, given to the fellow for his/her agreement of the meeting content, and a final copy will go into the fellow’s personal file. Unless otherwise stated, a fellow in Performance Warning Status is still considered to be in good standing and does not have to report this action on future professional applications. Should, however, the fellow be placed in Performance Warning Status again after the initial 3 month period, he/she is eligible to be placed on probation.

Should the fellow continue to be deficient despite appropriate counseling, professional assessment and input (if indicated), and faculty efforts, a period of probation (usually 3 months) is indicated. Before being placed on probation, the fellow will appear before a committee of one CV fellow, 2 CV faculty members and the Program Director wherein his/her case will be discussed. The fellow in question will have the right to rebuke the claims made against him/her. If his/her performance is deemed to warrant probation then formal written communication of probation will be drafted. Written communication of probation should:

1) State deficiencies that the individual was counseled for and document that insufficient improvement was made,
2) State explicitly that because of this the individual is being put on probation,
3) State period of probation,
4) State what is expected during this period,
5) State what will be done to assist the individual in meeting these expectations,
6) State what the mechanism(s) will be to determine improvement and
7) State what the consequences or options are to be if expectations are not met.

The deficient fellow will receive this written communication and a copy will go into his/her personal file. Fellows placed on probation may have difficulty with licensure in some jurisdictions. The probationary period is intended to emphasize to the fellow the importance of satisfactorily meeting the fellowship training requirements. The fellow should clearly appreciate the meaning of expected remediation, appreciate the defined time in which this must be accomplished, and alert his/her attending faculty during this period of probation to the importance of helping the fellow with defined problems. The faculty should provide an honest evaluation, should there be any possibility of personal problems, learning disability, or outside factors that may be contributory to the fellow’s performance.

Fellows on probation must achieve a satisfactory evaluation from their attending faculty on assigned clinical service rotations during their probationary period. Probationary actions will only be shared with those needing to know, and will not be disclosed to other fellows or students.

Should the fellow fail the above probationary period, then at the discretion of the Department, written communication extending the probation may be issued, or written communication dismissing the fellow from the program on a designated date will be issued, assuming that dismissal was a consequence of probationary failure as stated above. Accompanying this written communication must be a statement of the fellow’s right of appeal.

A fellow who may or may not have been on probation (and successfully accomplished remediation in the probationary period) may receive intermittent low satisfactory performance evaluations due to personal problems. While some individuals attempt to deal with such problems on their own, there are times when professional assistance can be helpful.
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It is in the best interests of the University, and its residents to provide assistance to those with personal problems involving alcohol, drugs, family, marriage, finances, emotions, or other conditions which may interfere with work attendance, productivity, and the ability to get along with co-workers. The University believes that an effective Assistance Program encourages wellness and promotes efficiency of its residents.

The University has a policy to maintain a drug-free workplace because drug abuse in the workplace may cause serious harm to any resident's health, work performance and social interactions. To avoid these adverse situations, the University encourages its residents to seek counseling and assistance from on-campus and community resources.

The School's Employee and Student Assistance Program is designed to provide information, assessment and referral services to help faculty, staff, residents and students identify problems and develop lifestyles that are physically and emotionally healthy. The University wants to encourage identification of problems at the earliest possible stage to motivate the residents or their families to seek assistance.

There are a number of resources available to residents experiencing personal problems:

18.1 The Department of Psychiatry
18.1.1 Offers a full range of inpatient, outpatient, and emergency services for the diagnosis and treatment of personal problems, including chemical dependency. The department is professionally staffed by psychiatrists, psychologists, and social workers and appointments may be made through the Psychiatry Clinic or individually through the private practices of these faculty members. Information about these services can be obtained by calling the Department of Psychiatry at 588-6400.

18.2 Kansas State Medical Advocacy Program
18.2.1 A Kansas medical license may be revoked, suspended or limited if a health care provider becomes unable to practice with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process, loss of motor skills or abuse of drugs or alcohol. Kansas law does provide a Medical Advocacy Program which providers can contact in lieu of contacting the Kansas State Board of Healing Arts. The goal of the Medical Advocacy Program of the Kansas Medical Society is to confidentially rehabilitate and support the provider whenever possible. Under the Impaired Practice provisions of the program, confidential assistance is offered to residents who suffer from chemical dependency or other forms of impairment. The phone number of the Medical Advocacy Program is 1-800-332-0156 or 1-913-235-2383. Informational brochures about these programs can be obtained from the Graduate Medical Education Office, the Student Center or the Dean's Office of School of Medicine. You may also contact the Risk Manager in the Office of General Counsel for further information.

18.3 University Counseling Center and the Psychological Clinic
18.3.1 Also available to KUMC residents is the counseling and educational support center located in the Student Center G116. The counseling center's contact number is (913)588-6580. Residents may find help with the following:
  • Training Exam coaching
  • USMLE Step 3 Preparation
  • Specialty Board Exam Assistance
  • Educational & Performance Excellence Coaching
  • Manage Stress/Time
  • Residency Demands
  • Personal Life Demands
  • Relationships / Marital / Family Concerns
  • Personal Counseling
  • Psychiatric Counseling
  • Consultation and Referrals
Crisis Intervention
Lending Library- in training & board exams

Counseling may be provided without cost or on a sliding-fee basis depending on the facility used. These facilities are staffed by professional-level or practicum counselors. All services are provided in the strictest of confidence.

18.4 State of Kansas HealthQuest
18.4.1 An additional source of assistance for residents needing confidential counseling, medical, and psychological support services is the State of Kansas HealthQuest, 24-hour, toll-free assistance line (1-800-284-7575); if referred through the HealthQuest, the first counseling session is paid by the State. All contacts are kept in strict confidence.

Residents may also contact or be referred to off-campus resources as appropriate. Counseling costs are often covered by health insurance with proper referral from the resident’s primary health care provider.

Ideally, the decision to seek counseling will be made by the affected resident, however, there may be situations where referral is recommended or required by the Medical Center, the School of Medicine, the Hospital Medical Staff, or the Officers of a resident’s program. Such situations generally arise when performance or behavior problems are observed in the course of supervision of the resident’s training. In these cases, the individual making the recommendation or imposing the requirement should not attempt to diagnose the problem(s). Rather, the resident should be encouraged to seek professional assistance.

GME Policies and Procedures Manual

For additional information please refer to the GME Policies and Procedures Manual.