



**Pediatric  
Electrophysiology  
Society**

**March 23, 2005**

Stephen C Hammill, M.D. President  
Heart Rhythm Society  
1400 K Street, NW, Suite 500  
Washington, DC 20005

Dear Dr. Hammill,

We are jointly writing to you as officers of the Pediatric Electrophysiology Society, in response to your recent e-mail correspondence with Jim Perry regarding training and certification for implantation of ICDs by pediatric electrophysiologists. The purpose of this letter is to inform you of our interest in participating with you and the leadership of the Heart Rhythm Society in the development of policies in this area. We sense that as the indications for ICD implantation expand, the federal government will be looking to the leadership of HRS for guidance on credentialing of clinicians. We want to make sure that you understand the current status of this issue as it has been discussed by the membership of the Pediatric Electrophysiology Society.

As a specialty, pediatric electrophysiology is much smaller than adult electrophysiology, in numbers of trainees, practicing specialists, and in the size of the patient population we serve. Similar to cardiothoracic surgeons, many in our specialty implant devices without being board-certified in adult electrophysiology, since that credential is restricted by the ABIM to those who have had internal medicine training. Unlike most cardiothoracic surgeons, who implant in essentially the same types of patients as do adult electrophysiologists, our patients are younger, smaller, with different substrates for arrhythmia, and often different indications for implantation. We also care for many patients with complex congenital heart defects, whose cardiac anatomy often poses particular challenges.

There is a consensus within our specialty that there is a specialized body of knowledge relevant to pediatric electrophysiology which is not necessarily possessed by all adult electrophysiologists. Over the last several years, there has been extensive discussion within our Society regarding the possibility that a separate board certification examination might be warranted for our specialty. However, the number of practicing pediatric electrophysiologists appears too few to make this practical at the present time.

In the meantime, we have participated in the development of training guidelines for pediatric cardiology and the different subspecialties of pediatric cardiology, as an intermediate step towards that goal. This process is essentially the same as the COCATS process, and a draft "ACC/AHA/AAP Training Statement on Pediatric Cardiology" is currently being reviewed by the three organizations prior to publication. That document

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*The Pediatric Electrophysiology Society*  
<http://www.pediatricesociety.org>

(currently embargoed) will address advanced training in pediatric electrophysiology in great detail, and includes specific expectations for implant volumes for trainees who wish to be device implanters, and these numbers are similar to those in the COCATS document for adult cardiology. As it happens, your suggestion that pediatric trainees gain experience in adult laboratories as needed had already been incorporated into that document. In addition, the writing committee recognized that pediatric implantation presents a different and unique set of problems for which skills need to be developed, and so a certain percentage of implants are to be required in younger children and patients with complex congenital heart disease.

While training guidelines are helpful, in the absence of board certification, we do not have a specific way to evaluate knowledge acquired, aside from informally within fellowship training programs. Your suggestion that NASPEXAM might be useful in this regard is persuasive, but there is a perception that this examination is so heavily weighted to adult clinical problems that is unlikely to be a complete tool for assessment of pediatric electrophysiologic knowledge or expertise. Still, it has a strong track record, and so we are discussing this possibility in our organization.

As a society, we will continue to analyze these issues, and would welcome the opportunity to discuss them with you further. We would also appreciate the opportunity to be involved in future debates on practice guidelines, reimbursement issues and certification questions such as this one which might affect us as a subspecialty, as you and the officers of HRS deem appropriate.

Respectfully.

James Perry, MD, President  
John Friedman, MD, Vice-President  
George Van Hare, MD, Secretary  
Richard Friedman, MD., Treasurer  
for the Pediatric Electrophysiology Society

*Reply to:*  
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