Interim Guidance for Training Programs in Philippine Adult Cardiology during the COVID19 Pandemic

A Special Report of the Joint Task Force on Adult Cardiology Training: the Subcommittee on Core Curriculum, Heads and Training Officers of various training programs, and the Specialty Board of Adult Cardiology, Philippine College of Cardiology/Philippine Heart Association
The Philippine Task Force for Adult Cardiology Training
May 2020

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1. INTRODUCTION

1.1. The existing core curriculum

The first local guideline devoted to a discussion of cardiology training in the country was released by the Philippine Heart Association-Philippine College of Cardiology in 2007.1 The latest update was released in 2017, with more detailed information regarding program outcomes, learning strategies and evaluation tools.2 This document was based on consolidated real-world data from the various accredited training programs of the Philippine Heart Association, helping the task force set minimum standards that would uphold quality without unnecessarily disenfranchising smaller but equally deserving programs. Since 2017, all programs sought to comply with such standards, ensuring that their graduates would satisfy the essential outcomes desired of a competent, compassionate, and well-rounded general cardiologist.

1.2. Rationale for the interim guideline

The field of cardiology has definitely been affected by the COVID19 pandemic, with the training aspect having its share of challenges and constraints. The effects of the enhanced community quarantine are far and wide, with clinical encounters and caseloads carrying the brunt of the impact. As a necessary response to this challenge, the Philippine Heart Association – Philippine College of Cardiology through the Specialty Board of Adult Cardiology deemed it imperative to engage key stakeholders in training. This interim guideline is intended to:

- Determine the challenges currently faced by Philippine training programs in adult cardiology
- Consolidate existing strategies and emerging solutions to address gaps in training brought about by the pandemic
- Formulate general recommendations to guide training programs in the country as they navigate the pandemic

This interim guideline is not viewed as a revision of the existing core curriculum document, but rather as a fitting supplement to assist trainers and trainees in the course of their work, with the ultimate goal of helping all graduates attain the desired program outcomes and maintain high quality standards through meaningful clinical exposures. The task force firmly believes that adaptive measures have to be considered during this time in order to foster an environment that will, by default, hardwire everyone for success.

1.3. Statement of the Problem

In an attempt to draft a clear guide for trainees and trainers, the Specialty Board of Adult Cardiology sought an audience with the various Chairs and Training Officers of its accredited training programs. The following were the main issues raised:

1) How will the Philippine College of Cardiology ensure that minimum quality standards in training are upheld by all training institutions amidst the logistical roadblocks brought about by the pandemic?
2) What are the perceived and real consequences of the lockdown brought about by the COVID19 pandemic, with respect to training in adult cardiology?
3) What remedial strategies can be considered to address the training issues above?
   a. Is there any need to revisit the core curriculum with respect to caseloads required (Appendix A)?
   b. Do we need to devise new strategies to help trainees meet training requirements?
   c. Is there a need to extend duration of training to meet the program as well as year-level specific learning outcomes (Appendix B)?
2. CHALLENGES BROUGHT ABOUT BY THE PANDEMIC

2.1. Challenges for Trainees

- **Burnout**: The reality of burnout in the profession of cardiology has already been established\(^3\) pre-COVID, but most certainly becomes magnified by the current pandemic. Based on the institutional set-up, some trainees were tapped to augment staff-power for COVID-related work, potentially placing some strain on their physical and psycho-emotional state.
- **Health risk**: Training fellows who go through the course of their hospital work are at risk of contracting COVID19 infection, most especially if they are deployed to high-risk areas such as the emergency department and intensive care units.
- **Reduced areas for clinical exposure**: Majority of outpatient services, particular clinical consultations, were put on halt by the COVID19 pandemic. Other patient services that were affected include elective procedures, particularly diagnostic, interventional and surgical.
- **Markedly reduced caseloads**: The pandemic has resulted in a drop in patient consults, admissions, and procedures. This, however, was somehow counterbalanced by the emergence of COVID-related cardiovascular manifestations in the inpatient setting.
- **Constrained timelines**: The expanded community quarantine has inevitably reduced trainee opportunities to catch up on required caseloads. Among the most affected are the graduating senior fellows, who are forced to meet the curricular requirements within the limited period of time prior to scheduled graduation.

2.2. Challenges for Trainers and Training Programs

- **Understaffing**: Some training programs were not able to recruit new fellows according to the prescribed timeline (April 1 is the date of training commencement). Others had issues regarding understaffing due to the need for quarantine of trainees with direct or indirect exposure to COVID19 settings, or inability of recruited trainees to report for duty due to regional lockdowns.
- **Modification of training landscape**: The pandemic has somehow shifted much of the focus of training programs to the service aspect, for good reason. Training-dedicated activities have taken a backseat to service-oriented strategies, in an attempt to address the growing demand for a responsive frontline workforce.
- **Lockdown on external rotations**: Inter-institutional partnerships for trainee exchange and preceptorship were affected, as fellows were not allowed to physically rotate in other hospitals due to the need for physical distancing.
- **Limitations to trainee engagement**: Avenues for trainee engagement have definitely been affected by the pandemic, both at the undergraduate and postgraduate levels. One obvious effect was the cancellation of in-person medical classes\(^4\) or physical meeting opportunities (e.g. congregation of trainees during exams and face-to-face oral evaluations were discouraged).
- **Impact on professional and career advancement**: The possibility of extended training in general adult cardiology has cast a great shadow of doubt on fellows being able to take board examinations as well as apply for subspecialty training on time.
3. PROPOSED SOLUTIONS AND RECOMMENDATIONS

3.1 Eyes on the prize: Focus on program outcomes

Cognizant of the limitations posed by various settings, as well as the unique mechanisms through which programs try to cope with the pandemic, the task force encourages all programs to continue existing efforts while keeping an eye out for innovative learning strategies that may apply to their setting. In essence, the task force recommends maintaining the existing grid of prescribed content areas, caseloads and competency levels (Appendix A). The task force is confident that such requirements may not need to be changed at this time, based on the assumption that the pandemic will fade in the not too distant future. As the task force is well aware of the reality of reduced caseload and clinical exposure, prescribed numbers in the existing curriculum are meant to serve as a standard barometer, but should not be a hindrance to the graduation of any particular trainee. The core curriculum committee came up with minimum caseloads essentially based on the real-world numbers provided by various accredited training centers in the country. Ultimately, the satisfaction of program outcomes through innovation and collaboration should serve as the key benchmark for all training programs. Towards this end, the task force shall implement regular re-assessment of the situation based on updated data provided by various training programs.

3.2 Complete rather than compete: Consider program partnerships

Institutions are highly encouraged to complete each other rather than compete with each other. High volume centers will be invited to share their cases (online) with smaller institutions. Such learning collaborations may be in the form of joint conferences, shared webinars, and multi-disciplinary sessions to maximize the full potential of the faculty resource in each institution. Identify institutions that particularly require assistance or lack subspecialty expertise, and provide avenues for them to avail of such.

3.3 Supplement rather than supplant: Explore blended learning strategies

Teaching and learning strategies prescribed by the core curriculum guideline must continue, but trainers need to exercise due diligence and best judgement as to which of these remain applicable and feasible in this time of the pandemic. Programs are encouraged to consider distance learning, e-learning, and other alternative modes of teaching and learning (Appendix C) in lieu of closed-in learning if they have the resources to do so. This approach of blended learning, or integration of face-to-face and online instruction, needs to be highly considered to augment existing strategies for instruction. Towards this end, the Philippine Heart Association must provide the logistical resources and avenues for all programs to be able to equally avail of such. Training institutions are encouraged to consider online, virtual and digital platforms of meeting, mentoring, as well as performance assessment.

3.4 The whole is not just a sum of its parts: Strive for holistic training

Beyond cognitive, psychomotor and attitudinal development, training programs must not overlook other equally important aspects of development: emotional health, psychological and mental wellness, physical welfare and social integration. Trainers have to consider alternative and more encompassing evaluation tools. Dedicated committees to specifically oversee trainee wellness and welfare will serve as a big boost to ensure holistic training and development.

3.5 Reinvent and repackage: Re-purpose existing resource materials

Training institutions are advised to compile clinical cases and records for ease of retrieval. Such resources can provide rich learning material for re-packaging and for sharing across institutions. The diagnostic aspect of cardiology can greatly benefit from this resourceful strategy, where archives of pre-recorded learning material (e.g. images or video clips of electrocardiograms, echocardiograms, and angiograms) are re-fashioned into fresh modules. Such materials can be shared across institutions through various digital platforms, with the necessary agreements and security measures put in place. Shared or re-used material, however, must be re-packaged to incorporate clinical correlation, to enhance the learning experience.
3.6 Evaluate and evolve: Monitor performance and re-assess

Each institution is advised to make the necessary modifications in the schedules of their training program to allow their trainees to comply with the required numbers and learning outcomes. Adjustments must be made to compensate for the numbers not achieved during a given timeline. Throughout this temporary period of adjustment, the SBAC shall actively monitor the progress of the institutions by requesting for **monthly census reports that state fellow-based numbers with respect to clinical and procedural caseloads**. Moreover, the SBAC will utilize the data provided to make decisions regarding any revisions in the curriculum content or program timelines, if the need arises. Post-training professional development of graduates must also be considered in the evaluation of training programs.

3.7 Uphold quality and competence: Maintain quality standards

Amidst the numerous strategies available to help fill in gaps in training, certain aspects may make the exception. **Learning areas and subspecialty domains that absolutely require physical encounters and repeated demonstration of psychomotor skills** (e.g. performance of intubation during TEE, introduction of catheters during invasive procedures, performance of DVT screening, etc.) **must adhere to minimum standards** set by the general as well as subspecialty cardiology expert societies. As such, various strategies must be entertained until the trainee meets the outcomes to the satisfaction of the training committee. As stated in the pre-existing core curriculum document, “The concept of mastery of the subject rather than just familiarization or exposure is key to ensuring a rich and high-quality pool of future cardiologists who will take the leadership role in clinical medicine and cardiology in the future.”

4. REFERENCES


5. APPENDICES

- **APPENDIX A**: Summary of Training Requirements – Learning Grid of Institutional Access to Resources, Basic Caseload, Competency Level, and Duration of Exposure recommended per Training Fellow
- **APPENDIX B**: Recommended learning outcomes (terminal competencies) per year level of training
- **APPENDIX C**: Alternative Platforms for Teaching and Learning
- **APPENDIX D**: Summary Infographic of the Interim Guidelines
### APPENDIX A

Summary of Training Requirements – Learning Grid of Institutional Access to Resources, Basic Caseload, Competency Level, and Duration of Exposure recommended per Training Fellow

<table>
<thead>
<tr>
<th>KEY LEARNING AREAS</th>
<th>PCC-SBAC 2017 RECOMMENDATIONS(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>ACCESS to learning resources</td>
<td>BASIC CASELOAD</td>
</tr>
</tbody>
</table>

#### CLINICAL CARDIOLOGY
- Outpatient or Stable-phase Cardiology
  - A2 800 C3 2X/week throughout program
- General inpatient (ward/floor rotation)
  - A3 1000 C3 10 mo
- Critical/Intensive Care and Coronary Care Unit
  - A3 500 C2 4 mo
- Emergency Cardiovascular Care
  - A3 600 C3 incorporated in rotations
- Cardiovascular Surgery
  - A3 40 C1 2 mo
- Perioperative cardiology (includes cardiac evaluation for noncardiac surgery)
  - A3 300 C3 incorporated in rotations
- Valvular/Congenital Heart Disease
  - A2 50 C2 2 mo
- Cardiac rehabilitation
  - A2 70 C2 1 mo

#### ELECTROCARDIOGRAPHY and AMBULATORY CARDIOLOGY
- Resting 12-lead EKG
  - A3 3500 C3
- Ambulatory EKG monitoring (holter monitoring)
  - A3 100 C3
- Ambulatory blood pressure monitoring
  - A3 ? C3
- Stress EKG (includes exercise and pharmacologic testing)
  - A3 300 C3

#### ELECTROPHYSIOLOGY, PACING AND ARRHYTHMIAS
- Pacemaker interrogation/programming
  - A2 40 C1
- Temporary pacemaker implantation
  - A2 5 C2
- Permanent pacemaker implantation
  - A2 10 C1
- ICD/CRT implantation
  - A2 2 C1
- Electrophysiologic interventions
  - A1 3 C1
- Electrical therapies in ACLS
  - A3 15 C3
- Elective electrical cardioversion of specific arrhythmias
  - A2 1 C2
- Tilt Table Testing
  - A2 10 C1

#### ECHOCARDIOGRAPHY
- Transthoracic echocardiography (M-mode, 2D, Doppler)
  - A3 800 C3
- Contrast echo (agitated saline)
  - A2 5 C3
- Stress echo (exercise and pharmacologic)
  - A3 100 C2
- Transesophageal echo (non-operative)
  - A2 15 C2
- Transesophageal echo (intraoperative)
  - A2 5 C2
- Periprocedural echo (pericardiocentesis, valvotomy, ASD closure)
  - A2 5 C1
- 3-dimensional/4-dimensional echo
  - A1 5 C1

#### VASCULAR MEDICINE
- Diagnostic evaluation of various disease states
  - A2 80 C3
| Management of specific vascular conditions (outpatient, inpatient, and critical phase vascular conditions) | A2 | 100 | C3 |
| Vascular ultrasound (carotid, peripheral arterial/venous; includes 20 hands-on performance of ABI) | A2 | 100 | C2 |
| Magnetic resonance angiography, CT aortography | A1 | 5 | C1 |

**NUCLEAR CARDIOLOGY**

- Myocardial perfusion imaging (SPECT, PET, Planar with Technetium and/or Thallium, imaging and stress protocols, viability assessment)  
  A2  50  C2
- Equilibrium radionuclide angiography  
  A1  1  C1

**OTHER RADILOGIC IMAGING MODALITIES**

- Cardiovascular MR  
  A1  5  C1
- Computed tomography  
  A1  5  C1
- Chest Radiography  
  A3  500  C2

**CARDIAC CATHETERIZATION**

- Diagnostic catheterization  
  A3  -  C1
- *coronary and LV angiography*  
  A3  100  C1
- *invasive hemodynamic studies (right-heart cath)*  
  A2  5  C1
- Interventional catheterization  
  A3  -  C1
- *percutaneous intervention (angioplasty, valvuloplasty)*  
  A3  40  C1
- Hemodynamic monitoring  
  -  -  C1

**SPECIAL CARDIAC PROCEDURES**

- Venous and arterial puncture  
  A2  10  C3
- Central line access (Internal jugular catheter insertion)  
  A2  5  C2
- Pericardiocentesis  
  A2  1  C2

**PREVENTIVE CARDIOVASCULAR MEDICINE**

- Cardiovascular biology  
  A3  -  C3
- Clinical epidemiology  
  A3  -  C3
- CV pharmacology  
  A3  -  C3
- Behavioral and Psychosocial aspects of CVD  
  A3  -  C3
- Risk assessment  
  A3  -  C3
- Assessment of subclinical atherosclerosis  
  A3  -  C3
- Risk factor management  
  A3  -  C3
- Disease management  
  A3  -  C3

**CORE LECTURES AND SPECIAL TOPICS**

- Cardiovascular history-taking and physical examination  
  A3  -  C3
- Ethics and legal issues in the practice of medicine  
  A3  -  C2

**RESEARCH**

- Research Methods (literature study, hypothesis formulation, protocol development, data collection/analysis, results, etc.)  
  A3  -  C2
- Critical Appraisal of Literature  
  A3  3  C3
- Systematic Reviews  
  A3  1  C2
- Observational and Experimental Studies, or Registries  
  A3  1  C2
- Case Reports/Case Series  
  A3  1  C2

*The minimum caseloads were obtained by taking into consideration the actual caseloads of the PHA-accredited training institutions.*

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APPENDIX B
Recommended Learning Outcomes (or terminal competencies) per year Level of training

YEAR LEVEL 1:
At the end of the first year of training, the trainee should be able to:

1. Establish a physician-patient relationship founded on trust and empathy.
2. Obtain a comprehensive clinical history with particular emphasis on cardiovascular conditions.
3. Perform a complete physical examination, including but not limited to a thorough examination of the heart and vascular system.
4. Explain the pathophysiology, diagnosis and management of common cardiovascular diseases.
5. Understand the indications, contraindications, application and limitations of non-invasive diagnostic tools.
6. Demonstrate rational options for treatment of basic and common cardiovascular conditions.
7. Demonstrate the basic skills in critical appraisal of scientific literature and commence a research project (original paper) through the creation of a research protocol.

YEAR LEVEL 2
At the end of the second year of training, the trainee should be able to:

1. Effectively communicate and collaborate with other members of the healthcare team.
2. Eloquently convey and discuss information obtained from history-taking.
3. Demonstrate adequate supervisory and teaching skills with respect to the cardiovascular physical examination performed by junior fellows, residents, and medical students.
4. Demonstrate a logical approach to the diagnosis of cardiac diseases or cardiovascular complications of noncardiac medical conditions.
5. Display good judgment and ethical decision-making in the selection, application, and interpretation of cardiovascular diagnostic modalities according to the clinical condition.
6. Confidently manage simple cardiac conditions and complicated cardiovascular cases.
7. Display excellent presentation and communication skills with respect to research-related activities.

YEAR LEVEL 3
At the end of the third year of training, the trainee should be able to:

1. Demonstrate a high degree of professionalism in the expression of views and opinions related to various issues in cardiology befitting a status of a consultant in cardiology.
2. Demonstrate critical thinking in the assimilation and application of information obtained from history-taking and physical examination.
3. Demonstrate excellent teaching and presentation skills in medical education through mentoring of junior fellows, residents, and medical students during patient rounds and conferences.
4. Synthesize information derived from the patient history, physical findings, and ancillary tests to arrive at the most logical and comprehensive cardiovascular assessment.
5. Demonstrate expertise in the performance of special cardiac procedures and the interpretation of invasive and advanced cardiac tests (e.g. hemodynamic and angiographic data, transcatheter interventions, indications and contraindications for permanent cardiac pacing and the long-term management of the pacemaker patient).
6. Demonstrate all-around expertise in the various phases of cardiovascular care: acute and critical care cardiology, stable phase of chronic cardiac care, rehabilitative cardiology, and out-patient care.
7. Completely write up (publication-ready manuscript) and present (orally at any scientific forum) at least one original research paper.
APPENDIX C
Alternative Platforms for Teaching and Learning

- **Institution-specific conferences**
  Majority of the training programs have their line-up of regular conferences (institutional, departmental, subspecialty) which have inevitably been affected by the pandemic due to logistical reasons. These can be sustained through online means (e.g. livestreams) using secure platforms for tele- or video-conferencing.

- **Joint-webinars (between training institutions)**
  Latching on to the idea of shared learning, bigger and more-equipped institutions are encouraged to partner with smaller ones by inviting trainees from the latter to join selected online webinars, particularly those that focus on subspecialty learning areas that may be lacking in their institution.

- **Supplementary educational webinars (PHA- or Specialty society-initiated)**
  As the mother society, the Philippine Heart Association is perfectly positioned to provide the much-needed universal support to its accredited training programs. PHA councils can be tapped to spearhead subspecialty sessions that can be made widely accessible, especially to training programs situated outside Metro Manila. The affiliate or component subspecialty societies may also be tapped to share their pool of talents and clinical resources for this purpose.

- **Digital repository of clinical cases (institution or PHA-driven; via website or other digital platforms)**
  Clinical material, whether patient-related or procedural in nature, may be compiled by the various institutions or centralized to the PHA for repackaging and posting online for shared access. Digital learning modules and skills laboratories (e.g. heart auscultation module, physical examination models, bedside procedure simulations) can be crafted to serve the specific learning needs of the various institutions.

- **Shared clinical material or patient encounters (e.g. one procedure or patient for multiple trainees)**
  To address the issue of insufficient clinical encounters and caseloads, training programs may opt to allow multiple trainees to share clinical material and patient encounters (e.g. one electrocardiogram or echocardiogram may be independently interpreted by two or more training fellows).

- **Online mentoring and trainee engagement (one-on-one or small-group)**
  Physical distancing has affected the mentor-mentee relationship at multiple levels. Trainers may opt to conduct one-on-one or small-group online mentoring sessions to regularly check on their mentees. A strong mentoring program is recommended to ensure timely monitoring of trainees’ progress. Opportunities for inter-institutional interaction are likewise encouraged, to foster camaraderie among trainees from various programs. Clinical materials as well as personal experiences may be shared during these sessions, while providing trainees the opportunity for real-time engagement with their consultants and mentors.
APPENDIX D
Summary Infographic of the Interim Guidelines

Cardiology Training: Coping with the Crisis
Interim Guidance for Training Programs in Philippine Adult Cardiology during the COVID19 Pandemic
Specialty Board of Adult Cardiology, Philippine College of Cardiology - Philippine Heart Association

EYES ON THE PRIZE
Focus on program outcomes
The satisfaction of program outcomes through innovation and collaboration should serve as the key benchmark for all training programs.

COMPLETE NOT COMPETE
Consider program partnerships
Institutions are highly encouraged to complement each other by sharing learning resources.

SUPPLEMENT NOT SUPPLANT
Explore blended learning strategies
Blended learning or integration of face-to-face and online instruction have to be considered to augment existing strategies for instruction.

WHOLE, NOT JUST PARTS
Strive for holistic training
Dedicated committees to specifically oversee trainee wellness and welfare will serve as a big boost to ensure holistic training and development.

REINVENT & REPACKAGE
Re-purpose existing resources
Shared or re-used material must be re-packaged to incorporate clinical correlation to enhance the learning experience.

EVALUATE & EVOLVE
Monitor performance and re-assess
Measures must be in place to monitor fellows not only with respect to clinical exposures and procedural caseloads, but also post-training professional development.

QUALITY & COMPETENCE
Maintain quality standards
Learning areas and subspecialty domains that absolutely require physical encounters and repeated demonstration of psychomotor skills must adhere to minimum standards.

This interim guideline is not viewed as a revision of the existing core curriculum document, but rather as a fitting supplement to assist trainers and trainees in the course of their work, with the ultimate goal of helping all graduates attain the desired program outcomes and maintain high quality standards through meaningful clinical exposures. The task force firmly believes that adaptive measures have to be considered during this time in order to foster an environment that will, by default, hardwire everyone for success.

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