From fellow to attending physician

BY PRABHJOT S. NIJJAR, MD

It doesn’t matter whether you are transitioning to a private or an academic practice; you face a quantum leap in responsibilities and an entirely new job description.

Much has been written about this vulnerable period, with many specialties taking steps to address the issues of transition. This period can be especially challenging when you transition from additional years of sub-specialty training or research beyond the typical three years of specialty/fellowship training.

I completed an advanced cardiac imaging (ACI) fellowship that consisted solely of training in cardiovascular computed tomography (CCT) and cardiovascular magnetic resonance (CMR). My early job also involved echocardiography and seeing patients in the clinic, duties that would be considered common practice for a cardiac imager. I found those duties to be a much harder transition than those involving reading CCT and CMR. Even though I had spent nine months in my general cardiology fellowship training in echo and had the requisite board certification, I felt ill-prepared to tackle the complexities of diastology or to get the perfect left atrial appendage view on trans-esophageal echocardiogram (TEE). Clinic visits felt awkward, as I had not had any direct patient contact over the previous year and it took a while to establish a comfortable rhythm. It made me realize that all the knowledge and procedural skills gained in my general fellowship training were still at a delicate stage. Taking a break from those skills so early on, when you haven’t developed adequate muscle and nerve memory, is perilous. Contrast this with a senior clinician who goes on a sabbatical and may find it relatively easy to return to clinical duties because they had flexed those muscles for many years before the time away.

This, of course, is a relatively common scenario: an interventional or electrophysiology graduate may be expected to use clinical skills they trained in—but haven’t practiced for one or two years. Similarly, those doing dedicated research training often have to take on clinical duties after a long hiatus. This transition can be especially abrupt with imaging fellowships. Accreditation Council for Graduate Medical education (ACGME) accredited fellowships (adult congenital heart disease, advanced heart failure and transplant cardiology, clinical cardiac electrophysiology and interventional cardiology) have continuity clinic built in as a requirement. But since cardiac imaging fellowships are not ACGME-accredited, they don’t have to follow the same rules. These fellowships tend to be more flexible in their structure. Most training sites have multimodality imaging available (some combination of echo, structural TEE, CCT, CMR and nuclear, including Positron Emission Tomography) and trainees have a lot of freedom to design their fellowships to meet their interests. Of the 55 clinical imaging fellowships listed on the ACC Advanced Imaging Training Program Database, 39 offer multi-modality training and 17 explicitly endorse flexibility in design. Many ACI trainees use this flexibility to focus on and master a specific imaging modality, often neglecting other essential imaging modalities. There is an urgent need to address this gap in imaging skills for early career (EC) cardiologists.

Steps to avoid losing touch with clinical skills

- Echocardiography/nuclear cardiology reading embedded in advanced training: Many advanced imaging fellowship programs have echo/nuclear training as part of a multi-modality platform, but a significant number of imaging fellowships focus exclusively on CT or MRI or both. This is understandable; a trainee may wish to gain deep expertise in a specific modality. One option is to have the trainee read echo/nuclear one half or full day a week. Many applicants going into an imaging program will have the requisite training for echocardiography/nuclear cardiology and can get hospital credentials for independent reading. Board certification in the required modality can be helpful to document competency. This serves the additional purpose of paying for a portion of the trainee’s salary.

- Direct patient care: Most sub-specialty fellowship trainees are board-eligible general cardiologists and can provide independent patient care. This can be set up as occasional weekend rounding on the in-patient general cardiology service so it doesn’t interfere with fellowship training that takes place during weekdays. Since cardiac imaging fellowships are not...
ACGME-accredited, specific ACGME duty-hour restrictions don’t apply. However, imaging programs should strive to follow best practices and adhere to duty-hour restrictions so as not to impact patient care. If weekend work is available, trainees can pro-actively apply for state medical licensure and hospital credentials—these processes are both slow and can take many months. Direct patient care also serves the additional purpose of paying for a portion of the trainee’s salary.

- **Moonlighting**: Many of us have practiced moonlighting at some point to supplement our relatively meager trainee salaries. Many cardiology practices offer opportunities for senior cardiology trainees to do weekend rounds. Duty-hour restrictions should be adhered to by trainees. Moonlighting can be especially beneficial to those involved in dedicated research, with limited options for clinical care.
- **CME courses**: Modality-specific societies conduct regular review courses that are very popular. These can be timed to provide a refresher in the desired modality before starting a job.
- **Mentored transition**: Mentorship is critical during training and it remains critical during the early career period as well. It is common practice to be assigned a research mentor on starting an academic job. It is equally important to have a clinical mentor in your field. On starting my first job, my echo lab director scheduled me to work in the echo lab on the same days he worked there. Having mentored many EC cardiologists over decades, he honed his skills at providing help in a way that boosts confidence. I knew that if I struggled during a TEE with intubation or a particular view, help was close by. With this nurturing, my confidence grew quickly and I was ready to operate independently soon.

- **Gradual transition**: Practices should be mindful of the early career cardiologist’s recent training history. Skills that have not been recently used can be put to use gradually. For example, clinic/inpatient duties can be postponed or kept light until the physician’s lab skills are up to speed. The first few months are the most crucial, so it should not be a big burden on the practice’s master schedule. Allowing a new cardiologist to gradually aclimatize can be a rewarding long-term investment.

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**REFERENCES**

Accreditation Council for Graduate Medical Education. ACGME common program requirements. Available at: https://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf. Accessed September 8, 2018.


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