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Can you Have Your Cake and Eat it Too? Outpatient Cardiology Precepting Models

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Summary

Within cardiology, we train fellows in chronic disease evaluation, prevention, and management primarily in the ambulatory setting[1]. Outpatient clinical care education can occur through two principal modalities- a classic apprenticeship model or a fellows' clinic. The apprenticeship model involves assigning each trainee to a single attending's existing clinic. The fellow attends clinic with the selected attending and sees his or her patients. Trainees in a fellows' clinic evaluate new consultations and/or recent discharges, often without prior cardiology follow-up, and present these cases and his or her plan to a rotating cardiologist assigned to precept the fellows during that particular session.

Which model should cardiology fellowship programs choose? To evaluate the merits and limitations of both approaches, we propose three critical aspects to consider: patient volume, mentorship, and autonomy.

Patient Volume

The apprenticeship model leverages the existing infrastructure of an established cardiology practice. Given that a cardiology attending often has a full schedule with a steady influx of new referrals and follow-up patients, "no-show" visits are less common. This affords the fellow ample opportunities to see new consultations and follow-up patients at varying stages of their clinical trajectory. In the fellows' clinic model, "no-show" visits may be more common as the referral base primarily consists of discharge follow-ups. Most notably, longitudinal patient encounters are harder to come by unless inherited from fellows after graduation[1].

Mentorship

In the apprenticeship model, the cardiology preceptor becomes a de-facto clinical mentor who also serves as a sounding board for both clinical and professional crossroads that arise within and outside their weekly clinic session together. On the other hand, the fellows' clinic allows a fellow to work with multiple cardiologists in the outpatient forum and hence an opportunity to network with more faculty members. Such relationships can enhance fellows' clinical development and provide further research opportunities.

Autonomy

Due to the variability of the apprenticeship model in regards to preceptor style, some fellows perceive themselves as relatively independent subspecialists while others as merely well-trained observers. A fellows' clinic aims to provide maximal autonomy. A patient in a fellows' clinic more likely views the fellow as his or her primary cardiologist.

Table 1: Attributes of Apprenticeship and fellows' clinic Models

	Apprenticeship	fellows' clinic
Patient volume and case-mix	High	Variable
Mentorship	Singular	Breadth of experiences
Autonomy	Variable	High

Our experience

Our institution has traditionally employed an apprenticeship model for outpatient cardiology fellowship education. As expected, trainees appreciate the high volume of patients at various points in their longitudinal care and relish witnessing the instinc-

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tive actions and learning the style of a particular clinical expert. Importantly, the life-long professional relationships generated from the weekly preceptor-preceptee encounters are unique and priceless.

However, critics perceive a lack of autonomy with this model, which fellows often crave as they prepare for life as independent cardiologists. Patients may not recognize a fellow as their "true" doctor, but rather as the inexperienced trainee they must tolerate prior to seeing the attending decision-maker. Indeed, patients can struggle to connect with a temporary "assistant" they suspect will be replaced within a few years[2].

To combat these perceptions and logistical hurdles, our clinical cardiologist preceptors expect their fellows to evaluate most new patients on their schedule and subsequently arrange these patients' follow-up visits during a time when the fellow will again be present. Ideally, a fellow establishes his or her own "mini-panel" within the attending's larger cohort. This practice, along with dedicated fellow clinic slots and re-directing all testing results, calls and messages from patients whom fellows have seen, are helpful but are limited by the trainees' inpatient clinical demands, particularly early in fellowship.

Future directions: a mixed model

Combining the clinical volume and powerful mentor-mentee relationships in the apprenticeship model with the autonomy and diverse perspectives encountered with a dedicated fellows' clinic requires creativity and buy-in from faculty. We propose the following three strategies to employ a mixed model:

***Shorten the term of service with one clinical preceptor*:** Limiting a fellow-attending pairing to eighteen to twenty-four months may allow fellows a second longitudinal experience during their training period. Though this would terminate some longitudinal patient relationships with the initial preceptor early, the opportunity to practice with a second attending seems warranted.

***Add supplemental opportunities*:** Create new ambulatory opportunities for cardiology fellows such as an additional, less-frequent continuity clinic or a two-to-four-week outpatient elective, during which a fellow rotates with many physicians in the group with expertise in different clinical niches. Both of these can diversify the fellow ambulatory training experience. With the addition of outpatient clinical experiences, fellowships should be mindful of excessive documentation requirement that may accumulate with these clinics.

Encourage Fellows to be present for patients

Finally, and most critically, by actively challenging fellows to rise to the occasion for their patients, fellows will take more ownership over their patient panel. Encourage fellows to ask patients about their hobbies and family life. For complex cases, ensure they call patients to check-in shortly after an encounter or visit them during an admission or before/after a procedure such as a coronary angiogram or pulmonary vein isolation. These simple gestures can solidify the patient-physician relationships fellows crave.

Both traditional ambulatory training models for subspecialty fellows provide strong clinical and educational experiences. Melding aspects of the apprenticeship and dedicated fellow clinic models maximizes clinical volume and autonomy while fostering consequential mentor-mentee and fellow-patient relationships.

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