A qualitative evaluation of the trainees' experience of assessments in the MMC foundation programme

The foundation programme for training junior doctors officially started in August 2005, with one key component being assessment of competencies. This qualitative study examined the opinions of foundation programme trainees regarding the perceived use of the assessments for training purposes and where the difficulties lay in completing assessments. Early identification of possible pitfalls should help improve the system for future trainees.

The Modernising Medical Careers (MMC) foundation programme for training junior doctors between medical school and specialty training officially started in August 2005. One of the key components of this foundation programme is systematic assessment of key competencies (Department of Health, 2004). This includes the use of four major evaluation types (*Figure 1*): mini-clinical evaluation exercise (mini-CEX); case-based discussions (CbD); directly observed procedural skills (DOPS); and multi-source feedback (MSF). All these have been proven to be robust assessment instruments (Durning et al, 2002; Norcini et al, 2003; Hesketh et al, 2005).

A survey of trainees in the Oxford deanery F2 pilot scheme (Limbert et al, 2005) identified some worries that trainees had with the foundation assessments. In August 2005 a new cohort of foundation year 1 (F1) and foundation year 2 (F2) trainees began a year's rotation in the Oxford deanery. This study aimed to evaluate this new cohort's experience of these assessments.

The aims of this questionnaire were threefold:

1. To assess the opinions of all the foundation trainees to determine who completes the assessments, how difficult it is to complete the assessments, what the difficulties are and how useful the assessments are for training
2. To compare the views of the F1 and F2 doctors
3. To compare the views of trainees in different specialties.

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Given that this is the first year of the foundation programme, early identification of possible pitfalls of assessments would be valuable to improve the system for future foundation trainees.

Methods

This qualitative evaluation used a structured questionnaire to collect data. Trainees were informed that the questionnaires were anonymous. Questionnaires were given out at organized meetings with educational supervisors, which were compulsory for all foundation trainees to attend, and teaching sessions. The questionnaire was written by the first authors of this paper who are both foundation trainees. Response rates were 69% (34 out of 49) for F1 doctors and 60% (28 out of 47) for F2 doctors.

The content of the questionnaire was as follows:

- Which year of training are you in? (F1/F2)
- Which post did you start in August 2005?
- How many of each type of assessment form (mini-CEX, CbD, DOPS) have you completed and who completed each one (nurse, registrar, educational supervisor, other consultant)?
- How difficult was it to complete each type of assessment?
- Where did the greatest difficulty lie?
- How useful was it completing each type of assessment?
- How could the assessments be made more useful for your training and learning purposes?
- Who were the assessors for your MSF?
- How easy was it to complete the MSF?
- Where did the greatest difficulty lie in completing the MSF?
- How useful was the feedback from your MSF?

Medical, surgical, paediatric and other specialties were represented (*Table 1*). Other specialties included rotations in psychiatry, intensive care unit, obstetrics and gynaecology, public health, general practice, trauma, accident and emergency, and biochemistry.

Figure 1. A brief description of each type of assessment.

Mini-clinical evaluation exercise (mini-CEX)
An assessor (registrar or consultant) observes a trainee taking a history or examining a patient and then gives feedback. Six of these assessments need to be completed during a foundation year 1 (F1) or foundation year 2 (F2) year

Case-based discussions (CbD)
An assessor (registrar or consultant) discusses with a trainee a case that they have been involved with, including appropriate management and follow up. Feedback is given. Six of these assessments need to be completed during a F1 or F2 year

Directly observed procedural skills (DOPS)
An assessor (nurse, registrar or consultant) watches a trainee perform a practical procedure and gives feedback. Six of these assessments need to be completed during a F1 or F2 year

Multi-source feedback (MSF)
The trainee chooses eight potential assessors from a choice of doctors of any level of seniority, nurses and other health professionals. These assessors then complete assessment forms about the trainee's performance in general in their own time and results are collated and fed back to the trainee

Each trainee has a consultant as an educational supervisor and they are obliged to complete at least one assessment for each trainee

For many of the questions, the trainee would rate each type of assessment. For the purposes of analysis, the results were combined to give an overall rating for the assessments as a whole. For example, when the trainees were asked how difficult it was to complete each type of assessment, 60 trainees rated each of the three assessments (mini-CEX, CbD and DOPS) giving a total of 180 replies.

Results

How difficult was it to complete each type of assessment?

The completion of assessments was rated as very easy or easy by 22% of respondents (40 out of 180 replies). However, 34% (61 out of 180 replies) rated the assessments as difficult or very difficult.

The F1 group found the forms in general more difficult to complete than the F2s. A total of 45% of F1 replies (40 out of 89) found the assessments difficult or very difficult compared to only 21% of F2 replies (18 out of 84).

Those in paediatrics and other specialties found the forms easier to complete: 19% of replies in paediatrics (5 out of 27) and 18% (6 out of 33) in other specialties rated the forms as difficult or very difficult to complete. In comparison 41% of replies (28 out of 69) in medicine and 43% (22 out of 51) in surgery rated the forms as difficult or very difficult.

Where did the greatest difficulties lie in completing the assessments?

The three greatest difficulties in completing the assessments were: the time taken for the assessor (25% of replies; 15 out of 60); getting the assessor to agree to complete the form (23%; 14 out of 60); and finding suitable clinical situations in which the assessment could be undertaken (22%; 13 out of 60).

These were the prominent replies in both year groups and across specialties.

How useful were the assessments?

The forms were rated as useful or very useful for training purposes by 48% of respondents (79 out of 165 replies).

The F2 trainees found the forms in general more useful than the F1s. Of the F2 replies 68% (51 out of 75) compared with 31% (28 out of 90) of the F1 replies rated the forms useful or very useful.

More replies from those doing paediatrics (58%; 15 out of 26) and other specialties (78%; 21 out of 27) found the forms useful or very useful compared to those doing surgery (42%; 21 out of 50) and medicine (35%; 22 out of 62).

How can the assessments be made more useful?

The three top rated changes to make the assessments more useful were: the same assessor being able to complete multiple forms (28%; 12 out of 43 replies); assessors being of any level of seniority (26%; 11 out of 43 replies); and finding clinical situations that are more valuable (23%; 10 out of 43 replies).

Difficulty of completing the MSF and value of feedback?

Only 7% of trainees (4 out of 56) rated the MSF difficult or very difficult to complete. The greatest difficulties were: time taken to find and explain the process to the required number of assessors (31%; 10 out of 32 replies); approaching potential assessors (28%; 9 out of 32 replies); potential assessors already filling in forms for other foundation trainees (19%; 6 out of 32 replies).

The MSF was rated as useful or very useful in 64% of replies (23 out of 36).

Who completed each type of assessment?

Registrars and consultants completed similar numbers of assessments. In total 92 registrars completed between 1 and 2 assessments each compared to 87 consultants.

Table 1. Specialties represented in the questionnaire

Specialty	Total number	F1 doctors	F2 doctors
Medicine	24	17	7
Surgery	18	13	5
Paediatrics	9	4	5
Others	11	0	11

Discussion

How difficult was it to complete each type of assessment?

Grade of doctor

F2 doctors may have found the assessments easier to complete for a number of reasons. F2 doctors have more experience working as a junior doctor, hence they may have more confidence in their ability. This may make it easier for them to approach senior doctors and ask them to complete assessments.

F2 posts have recently been created for the foundation programme, hence the job is more compatible with foundation programme requirements including assessments. The F1 jobs on the other hand are mostly traditional preregistration house officer posts in medicine and surgery where assessments were not previously required. Therefore many of the potential assessors for F1 doctors are not aware that a change has occurred. This may change with time as the foundation programme and the F1 posts become more established.

In addition, the F2 posts are a pilot scheme which the doctors chose to apply to. The F1 doctors, however, had no choice as to whether to join a foundation programme or not. F2s may therefore have a more positive attitude to the system than the F1 doctors.

Specialty of doctor

Those in paediatrics and other specialties may have found the assessments easier to complete than those in medicine and surgery for a number of reasons. Paediatrics and the other specialties tend to be small departments with close teamwork. The job is less busy and the trainees move teams less often than in medicine and surgery. In surgery, for example, the trainee can move teams as often as once a week. Therefore trainees working in paediatrics or other specialties are able to easily approach members of their team who have seen their performance on numerous occasions. Additionally, both the trainees and the assessors may have more time to complete the assessments. In medicine and surgery there may be diminished responsibility on the part of assessors to complete assessments because they do not have to see the trainee on a regular basis.

Data from the assessor training programmes in the John Radcliffe Hospital show that registrars and consultants from

paediatrics and other specialties are more likely to go to training sessions. Of all those who attended training sessions only 2% were from general surgery, 9% were from general medicine and 9% from paediatrics. This poor attendance by surgical assessors could partly explain why trainees in surgery find completing assessments difficult.

As discussed before, many of the specialty posts have been created for the foundation programme whereas medical and surgical posts have been longstanding and have not changed greatly for the foundation programme.

The majority of the specialty posts are in the F2 year and as discussed, F2 doctors may be more confident and have more experience of completing assessments.

Training for foundation doctors may help encourage confidence in approaching assessors. Potential assessors from medicine and surgery could be encouraged to attend training sessions to teach them about the existence and role of the assessments.

Where did the greatest difficulties lie in completing the assessments?

The assessments were rated as difficult or very difficult by 34% of foundation trainees. This is a significant problem that needs to be addressed. The major difficulties highlighted by the trainees were getting the assessor to agree to complete the form, the time taken for the assessor and the difficulty in finding suitable clinical situations. Interviews with pilot F2 trainees by Limbert et al (2005) also discovered that trainees were having difficulties with finding assessors with sufficient time to watch them perform a task and complete the form. These difficulties may have occurred simply because this is a new system. The potential assessors may be unaware of the importance of the forms for the trainee. The assessors may also be unfamiliar with the forms and they therefore take much longer to complete. Both the assessors and the trainees may find it difficult to find the time to complete assessments.

These problems may be overcome as the foundation programme becomes more established over the years; trainees and assessors will gradually become more familiar with the assessments. Training sessions for trainees could provide advice for finding useful and appropriate clinical situations. Training sessions for assessors will explain the use of assessments, how they are completed and their importance. Dedicated time slots for assessments (e.g. outpatient clinics) may be beneficial. Additionally, assessors may become more willing to complete the forms if being an assessor for the foundation programme is in their contract. Alternatively senior doctors with an interest in teaching and training could volunteer to be assessors.

How useful are the assessments for training purposes?

Grade of doctor

F2 trainees may find the assessments more useful than F1s for several reasons. As shown F2s find the assessments easier to complete and therefore may use them in situations more useful for their training. F1 trainees, however, may use all opportunities available in order to complete assessments, rather than in the most valuable clinical situations.

F2 trainees may have more experience in knowing which situations would be best for their training purposes.

Specialty of doctor

Those doing paediatrics and other specialties may have found the forms more useful than those doing medicine and surgery for several reasons. The specialty departments may be less busy, giving more time for completing each assessment as well as for constructive feedback.

In the smaller specialties the assessors are likely to have seen the trainee perform on many occasions and this may make the assessment more useful.

More assessors from paediatrics and other specialties attended training sessions and so each assessment may be more productive and fulfilling.

How can the assessments be made more useful?

The same assessor being able to complete multiple forms and assessors being of any level of seniority were rated highly as factors that could make the assessments more useful. This particularly applies to the smaller departments where there are fewer senior staff or the trainee only regularly works with a few individuals. However, allowing the same assessor to complete multiple forms may introduce bias because the overall assessment process for foundation doctors is intended to be a result of an average of scores from multiple assessors. If one assessor completed multiple forms, this average may not be representative. Additionally, if doctors of any level of seniority were permitted to be assessors, the validity of the assessment process may be reduced because junior doctors may be less likely to accurately assess the clinical ability of a trainee.

Finding valuable clinical situations was also rated highly and, as discussed above, training sessions for foundation doctors could help them to identify such clinical situations.

Difficulty completing the MSF and value of feedback

The MSF was the easiest assessment to complete. This may be because assessors can complete the MSF in their own time, away from the trainee and so are more willing to do so. It was also rated the most useful of the assessments. Time taken to find and explain the process to the required number of assessors and approaching potential assessors were identified as difficulties. This may improve with time as assessors become familiar with the process and complete multiple MSFs each year.

Potential assessors already filling in forms for other foundation trainees was also identified as a difficulty. This may be less easy to overcome because there will always be limited numbers of assessors. The same assessor may be chosen for various reasons by multiple trainees, e.g. they are more approachable, they worked closely with the trainee or the department is small. One way to solve this may be to assign the assessors to the trainees so that an assessor only has to complete one assessment, but this removes the trainee's ability to choose who assesses them which is an important part of MSF.

Who completed each type of assessment?

Although it was found that registrars and consultants completed the same number of assessments for trainees, data from the assessor-training programme show that consultant attendance at training sessions was much higher than that of registrars. Of all those who attended these sessions 58% were consultants compared with 18% of registrars. This may indicate that even though registrars are completing many assessments, they are not receiving as much training to do so, which may

make the assessments less beneficial for training. Although training sessions are not compulsory, registrars should be encouraged to attend.

Improvements for future years of foundation training

- More training (and compulsory) sessions for assessors. Try to encourage assessors from all departments and of all seniorities to attend
- Being an assessor and/or attending training sessions as part of the job contract
- Encourage medicine and surgery departments to adapt their jobs towards the new foundation programme rather than the old preregistration house officer jobs
- Training sessions for foundation doctors, which will include how to find valuable situations for assessment and build confidence in approaching potential assessors
- Dedicated time slots for assessments.

Follow up

The authors hope to distribute the questionnaire to trainees again later in foundation training to identify any changes. BJHM

Conflict of interest: none.

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KEY POINTS

- Foundation year 1 trainees have more difficulty in completing assessments and find them less useful than foundation year 2 doctors.
- Trainees in paediatrics and other specialties find the assessments easier to complete and more useful than those doing medicine and surgery.
- The greatest difficulties in completing forms were the time taken for the assessor and getting the assessor to agree to complete the form.
- It was thought that the same assessor being able to complete multiple forms for one trainee and the assessor being of any level of seniority could make assessments more useful.
- Finding valuable clinical situations for assessment seemed to be a major problem.
- The multi-source feedback was found to be the most useful assessment and the easiest to complete. It was thought that difficulties lay in approaching and explaining the process to assessors.

The ligated ureter: beware or be aware

A 75-year-old woman underwent abdominoperineal resection for a rectal adenocarcinoma, as well as total abdominal hysterectomy and bilateral sapingo-oophorectomy for cystic ovarian disease.

Postoperatively she complained of vague right-sided abdominal pain. Contrast computed tomography revealed right hydronephrosis with perinephric extravasation and a presacral urinoma (*Figure 1*). A right nephrostomy was inserted and a nephrostogram demonstrated complete obstruction of the distal right ureter at the pelvic brim (*Figure 2*) suggesting ureteric ligation.

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The patient underwent a successful ureteric re-implantation (Boari flap).

One must maintain a high index of suspicion for ureteric injury after major pelvic surgery, particularly if the patient has a difficult postoperative recovery with vague symptoms and signs. BJHM

Figure 1. Three-dimensional computed tomography intravenous urogram reconstruction demonstrating right hydronephrosis with perinephric collection (blue arrows) and anterior sacral urinoma (red arrow).

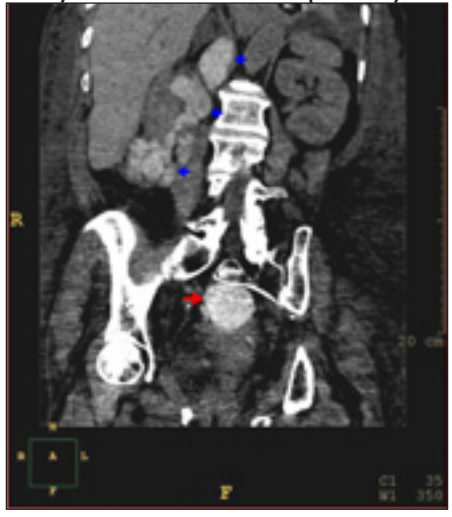

Figure 2. Nephrostogram showing obstruction of the distal right ureter with an abrupt cut off (blue arrow) at the level of the pelvic brim suggesting the diagnosis of a ligated ureter.