Reflections on foundation year 1

Introduction

As I approach the end of my foundation year 1 (FY1) I look back on what has been an interesting but at times difficult year. August 2005 heralded the start of working as a junior doctor, but along with many others I was now classed as an FY1 junior doctor. I was now one of many newly-qualified doctors becoming part of history as the first set of doctors embarking on the reformed postgraduate medical education and training programme as encompassed in *Modernising Medical Careers* (MMC) (Department of Health, 2005).

The foundation programme

The foundation programme consists of 2 years. Full registration with the General Medical Council (GMC) is achieved at the end of year 1 on satisfactory completion of all assessments and sign-offs. Successful completion of year 2 allows trainees to commence further specialist training.

Core competencies essential for FY1 are listed in the portfolio given to each trainee at the start of the year. Competencies are based on the principles described in *Good Medical Practice* (GMC, 2001). The portfolio becomes a record of achievements throughout FY1. Learning should be work-based, self-directed and using reflection upon personal experiences with personal study and audit expected.

Core competencies are assessed using a number of tools and trainees' assessments are completed by appropriate health-care personnel. Assessment tools include mini-peer assessment tool (mini-PAT) whereby trainees' behaviour is assessed by different team members; direct observation of doctor–patient interactions using mini clinical evaluation exercise (mini-CEX) and direct observation of procedural skills (DOPS); and case-based discussion (CBD).

My experience of FY1

The beginning

My FY1 at St Thomas' Hospital consisted of 3-month rotations in general medicine, paediatrics, orthopaedics and vascular surgery. On induction day, together with 40 others, I received the foundation learning portfolio and numerous other books and pamphlets related to the new foundation programme. In the first few weeks we were given pads of assessment forms for the year. The foundation programme was new to all team members and it was a case of picking things up as you went along.

The first month was a case of information overload trying to apply theory to practice, getting to grips with computer programmes, assessing patients, prescribing drugs, on calls and handovers. Assessment forms and self-directed learning seemed less of a concern particularly as few people were sure how they all worked. Uncertainties about the new training pathway and our futures instilled a sense of insecurity in most. However, once we started to find our feet on the wards, caring for patients, becoming proficient in completing discharge summaries (fondly known as TTOs – to take out), and prescribing basic drugs without doing harm we start thinking about the assessments.

As a trainee-centred programme it was up to each individual trainee to ensure all meetings, assessments and teaching happened. Some trainees preferred to spread assessments out over the year, some like me wanted to get as many done as early as possible while others preferred to wait until they felt they were more experienced and ready for assessments. The programme involved an induction, mid-term and end of rotation meeting with our educational supervisor (the consultant we were working with each rotation). It was intended that each trainee has a clinical supervisor and an educational supervisor – in my case they were the same person and therefore changed every 3 months. The clinical supervisor's role was to supervise day-to-day clinical and professional practice, support assessment process and allow fixed educational sessions while the educational supervisor's role was classed as supporting and developing the learning portfolio and training and assessing as required.

Meeting the consultant and planning objectives and goals for the rotations was time-consuming but useful. Personal development plans, reflective practice, educational agreements, and records of meetings with educational supervisor were all self-managed. My consultants took the programme seriously, had been trained as assessors for the foundation programme and were easily contactable, approachable and caring in the way they assisted with the whole process. Many of my colleagues were not so fortunate and spent time and energy trying to arrange meetings and assessment time with their consultants with meetings often held after moving to the next rotation. This happened more frequently on surgical firms.

The assessments

We had to complete six sets of each of the DOPS, mini-CEXs and CBD assessment forms during the year. It was easy to perform DOPS as a variety of health-care workers as well as consultants could act as assessors. Basic procedures such as venepuncture were performed often and easily assessed on the wards. Many procedures were not listed but could be performed depending on the firm you were with, for example those on chest firms managed to site chest drains.

CBDs were the most interesting and useful assessment tool. Cases were discussed often as part of a post-take ward round or at X-ray meetings. Cases were those I had clerked while on take, e.g. a patient admitted with exacerbation of Crohn's disease. My consultants all took time to later sit and discuss these cases individually, converting the time into a tutorial-type session where I had to answer questions about the case and could ask questions, making the most of the educational experience. Mini-CEXs were more confusing and difficult as it was expected that a consultant would be available to watch you take a history and/or examine a patient. This was unrealistic – consultants tended instead to assess these aspects from presentation of cases on post-take ward rounds.

Mini-PATs were carried out twice during the year and each time eight assessors were asked to give feedback on a form looking at clinical, communication, ethics and time management issues. A minimum of four assessors needed to reply to validate the

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process. A selection of health-care workers could be chosen – I asked consultants, registrars, senior house officers, staff grade nurses, specialist nurses and pharmacists. We received the replies and any feedback, both positive and negative, at a meeting with our FY1 tutor a month later. Each assessor could make separate comments as well as just ticking boxes on the form and my assessors all took time to make comments which were informative and encouraging. Each trainee completed a self-assessment form and this was compared to assessors' responses. For most questions I was more critical of myself than the assessors were. A graph was made comparing each trainee's results with their peers which was useful, as it was generally difficult to determine how you were doing in relation to your peers on a day-to-day basis.

Education

Throughout the year we had an hour of protected teaching time each Friday over lunch with a different speaker and topic each week. The interactive sessions involving case discussions were extremely useful. The lecture-style teaching was variable depending on the topic and tutor.

Ten action learning team sessions were held during the year, in which a group met with a tutor for an afternoon to discuss issues such as clinical governance, medical ethics or problems faced on the wards. This was a unique opportunity to share experiences away from the wards and for coaching by a tutor on more non-medical issues.

Grand round meetings were held once per week for an hour. There were many informative talks and it was a good way to receive an update on medical and surgical issues, although most presentations were not designed for FY1 doctors or as an aid to day-to-day working on the wards.

The simulation course, assessment of life-threatening emergencies (ALERT) course, and advanced life support course were all compulsory and warranted a certificate. These were the most enjoyable and useful teaching sessions we had. The 1-day simulation course involved real-life case scenarios acted out in real time using a robotic patient, with a nurse and back-up team at hand. Our performances were videoed and constructive and helpful feedback given. We all enthused about the course and would like to have done another day.

The ALERT course, also held over 1 day, allowed us to participate in emergency scenarios which we would be expected to deal with on the wards such as hypoglycaemia. Feedback from consultants was useful. Unfortunately owing to time and staffing issues many of us had to wait until our last rotation to do the ALERT course which was less beneficial – perhaps this could be changed in future. There was no formal teaching on the wards but depending on the team, informal teaching occurred on ward rounds and other occasions on the wards or in theatre. Pharmacists and nurses were a source of useful information without which we would have been lost.

There was little time for personal study during the day but some colleagues studied at weekends so they could sit and pass the Membership of the Royal College of Surgeons as it was felt that this may help secure competitive foundation year 2 (FY2) posts. There was ample opportunity, if little time, to participate in audits. I participated in two and presented an audit on self-harm in paediatric patients. There were opportunities to present cases at various meetings.

Work and time management

Ward work and time constraints are an age-old problem, not now made any easier by the addition of formal assessments and meetings. So what do you do? You learn to prioritize, apologize profusely, delegate as appropriate, get the jobs done without too much delay, meet with your educational supervisor, teach students, perform DOPS and fit in an occasional CBD and still finish at a reasonable time.

It is easy to stay late to do jobs which can wait until the morning. Taking annual leave is as difficult as it always has been. To meet working time regulations, junior doctors also had to complete time sheets over 2-week periods during the year, certainly testing our skills at completing forms.

Following FY1

As part of the first group of FY1 trainees no FY2 posts had been arranged as part of a 2-year programme which is the intention for the future. From December uncertainties about the future started to permeate our group. Where would we find an FY2 post, would we have to leave London, would we be able to get rotations that were of interest to us, and how do we apply?

The first set of FY2 jobs became available in December – a small number of academic posts which were rapidly filled. The second set of posts were advertised in February 2006 with the stipulation that FY1 trainees working outside London would have the first option of London posts. After they were allotted everyone else would be allotted to posts outside London or within the M25 if any remained. This caused grave concerns for those of us working in London. This had not been made clear to us in advance, and despite many discussions with organizers we had to comply with what was already decided.

Many FY1 trainees began to look abroad for opportunities. For those wanting to work in the UK completing the application forms caused many sleepless nights. The forms concentrated more on how you could answer questions relating to experience gained as an FY1 trainee and less on past academic achievements.

Despite all the stress and uncertainty most of my peers managed to get FY2 posts which were acceptable to them. But what happens next? Perhaps in 5 years time all the teething problems will have resolved and future FY1 trainees will not have to deal with so many uncertainties. BJHM

Conflict of interest: none.

Department of Health (2005) *Curriculum for the Foundation Years in Postgraduate Education and Training.* Department of Health, London (www.mmc.nhs.uk)

General Medical Council (2001) *Good Medical Practice.* General Medical Council, London (www.gmc-uk.org)

Further information

Operational Framework for Foundation Training (www.mmc.nhs.uk/pages/foundation/Operational-Framework)

Postgraduate Medical Education and Training Board (www.pmetb.org.uk)

KEY POINTS

- The foundation programme is here to stay.
- Modernising Medical Careers is a UK-wide initiative designed to explain, facilitate and develop principles underpinning a major reform in training of qualified doctors.
- There are a number of new assessment tools.
- Full General Medical Council registration takes place at the end of foundation year 1.
- Completion of foundation year 2 leads to commencement of a programme of specialist training.