

第1回医師臨床研修制度の到達目標・評価の在り方に関する  
ワーキンググループ  
議事次第

平成26年8月20日(水)  
16:00 ~ 18:00  
法曹会館高砂の間

- 開会
- 議題
  1. ワーキンググループ座長の選出について
  2. 到達目標・評価の在り方について
  3. その他
- 閉会

【構成員提出資料】

英国の医学教育臨床研修制度（田中構成員提出資料）

【事務局提出資料】

- 資料1 医師臨床研修制度の到達目標・評価の在り方に関するワーキンググループ開催要綱
- 資料2 到達目標・評価にかかる現状について
- 資料3 ワーキンググループの役割と今後の進め方について
- 資料4 到達目標とその評価の在り方に関する研究について
- 資料5 到達目標・評価の在り方にかかる論点について

参考資料1 臨床研修の到達目標

参考資料2 医道審議会医師分科会医師臨床研修部会報告書(平成25年12月19日)(抜粋)

参考資料3 医師臨床研修制度の評価に関するワーキンググループ～論点整理～  
(平成25年2月8日)(抜粋)

参考資料4 日本の人口・医療・介護の提供体制等関係資料

参考資料5 医学教育・国家試験・専門医関係資料

【机上配布】

- ・医道審議会医師分科会医師臨床研修部会報告書（平成25年12月19日）
- ・医師法第16条の2第1項に規定する臨床研修に関する省令の施行について（厚生労働省医政局長通知 平成26年3月31日）
- ・医学教育モデル・コア・カリキュラム—教育内容ガイドライン—（平成22年度改訂版）
- ・平成25年版 医師国家試験出題基準
- ・専門医制度整備指針（第1版）（2014年7月）

# 医師臨床研修制度の到達目標・評価の在り方に関する ワーキンググループ 開催要綱

## 1. 趣旨

医師臨床研修の実施状況や診療能力の修得状況等を把握し、医道審議会  
医師分科会医師臨床研修部会における臨床研修制度の次回の見直しに向  
けて、到達目標や評価の在り方についての検討をすることを目的に、本ワ  
ーキンググループを開催する。

## 2. 検討課題

- 臨床研修制度における到達目標の在り方について
- 臨床研修制度における評価の在り方について 等

## 3. 構成員

- (1) 別紙に掲げる有識者により構成する。
- (2) 構成員のうち1人を、座長として互選により選出する。
- (3) 座長は必要に応じ、関係者の出席を求めることができる。

## 4. 運営等

- (1) 本ワーキンググループは、原則として公開するとともに、議事録  
を作成し公表する。
- (2) 本ワーキンググループは、医政局長が主催し、その庶務は医政局医  
事課で行う。

医師臨床研修制度の到達目標・評価の在り方に関するワーキンググループ

構成員名簿

氏名	所属・役職
いの みゆき 伊野 美幸	聖マリアンナ医科大学医学部医学教育文化部門教授
おおたき じゅんじ 大滝 純司	北海道大学大学院医学研究科医学教育推進センター教授
かたおか ひとみ 片岡 仁美	岡山大学大学院医歯薬総合研究科地域医療人材育成講座教授
かねまる よしまさ 金丸 吉昌	美郷町地域包括医療局総院長
かんの まさひろ 神野 正博	社会医療法人財団董仙会理事長
こもり たかし 小森 貴	日本医師会常任理事
しみず たかこ 清水 貴子	社会福祉法人聖隷福祉事業団総合病院聖隷浜松病院副院長
たかはし ひろあき 高橋 弘明	岩手県立中央病院医療研修部長
たなか ゆうじろう 田中 雄二郎	東京医科歯科大学理事
なかしま とよじ 中島 豊爾	岡山県精神科医療センター理事長
ばん のぶたろう 伴 信太郎	名古屋大学医学部付属病院総合診療科長
ふくい つぐや 福井 次矢	聖路加国際病院長
ふるたに のぶゆき 古谷 伸之	東京慈恵会医科大学内科准教授
まえの てつひろ 前野 哲博	筑波大医学医療系臨床医学域教授

## 到達目標・評価にかかる現状について

### 1. 到達目標について

- 臨床研修の到達目標については、「医師法第16条の2第1項に規定する臨床研修に関する省令の施行について」（厚生労働省医政局長通知 平成26年3月31日）（以下、「施行通知」という。）において、「臨床研修の到達目標」（別添1）（参考資料1参照）として掲げられており、Ⅰ行動目標（医療人として必要な基本姿勢・態度）、Ⅱ経験目標（A 経験すべき診察法・検査・手技、B 経験すべき症状・病態・疾患、C 特定の医療現場の経験）により構成されている。
- この「臨床研修の到達目標」は、臨床研修制度必修化以降、基本的にその内容は変更されていない。
- また、施行通知において、研修プログラムにおける「臨床研修の目標」は、別添1に示された「臨床研修の到達目標」を参考にして、研修病院が当該研修プログラムにおいて研修医の到達すべき目標として作成するものであり、「臨床研修の到達目標」を達成できる内容であることとされている。

### 2. 評価について

- 臨床研修病院における評価については、施行通知において、以下の通り行うこととしている。
  - ・ 指導医等が、研修医ごとに臨床研修の目標の達成状況を把握し、研修医に対する指導を行い、担当する分野における研修期間の終了後に、研修医の評価をプログラム責任者に報告
  - ・ 基幹型臨床研修病院の管理者やプログラム責任者等からなる研修管理委員会は、指導医やプログラム責任者からの情報提供等により、研修医ごとの研修進捗状況を把握・評価し、研修医の研修期間の終了に際し、臨床研修に関する当該研修医の評価を行い、管理者に対し、当該研修医の評価を報告
  - ・ 管理者は、研修管理委員会における評価に基づき、研修実施期間や臨床医としての適性の評価とともに、臨床研修の目標の達成度の評価を行い、それぞれの基準が満たされた場合に臨床研修の修了を認定

- また、評価方法については、施行通知において、以下の通り示されている。
  - ・ 研修期間中の評価は、研修医ごとの研修内容を改善することを主な目的として、形成的評価により行うことが重要であるとされ、研修医及び指導医は、「臨床研修の目標」に記載された個々の項目について、研修医が実際にどの程度履修したか随時記録を行う
  - ・ 研修期間終了時の評価は、研修医ごとの臨床研修修了の判断を行うことをその目的として、総括的評価により行うこととし、研修実施期間の評価及び臨床研修の目標の達成度の評価、臨床医としての適性の評価に分けて行う
- 大学病院及び研修病院において、採用している研修医の評価方法は様々であり、「指導医による評価」「症例レポート」「コメディカルによる評価」の順に多く、「口頭試問」「実技試験（OSCE<sup>※1</sup>）」「患者による評価」等は少ない。
- 到達目標の達成度を記録するツールとして、制度導入当初から運用されている EPOC<sup>※2</sup>については、全国の約6割の研修医が利用している。
- 米国、英国、仏国の臨床研修制度においては、研修医、指導医、研修プログラムに対する評価が多角的に行われており、特に英国はインターネット（e-ポートフォリオ等）の活用が進んでいる。

※1 Objective Structured Clinical Examination（客観的臨床能力試験）

※2 Evaluation system of Postgraduate Clinical training（オンライン卒後臨床研修評価システム）

## ワーキンググループの役割と今後の進め方について

- 医道審議会医師分科会医師臨床研修部会報告書（平成25年12月19日）（以下、「部会報告書」という。）において、到達目標とその評価については、人口動態や疾病構造の変化等の観点から、その内容を見直す必要があるとの指摘があり、今次見直し（平成27年度適用）ではなく、次回見直し（平成32年度適用）に向け検討することとなったところ。（参考資料2参照）
- 「医師臨床研修制度の到達目標・評価の在り方に関するワーキンググループ」では、到達目標とその評価の在り方に関し、部会報告書において指摘された方向を踏まえ検討を進めていく。
- これらの検討に際し、以下のスケジュールのとおり、別途行われている厚生労働科学研究<sup>\*</sup>からの報告等を踏まえ、関係者のヒアリング等を行うこととしてはどうか。

### （今後のスケジュール案）

- |                |  |
|----------------|--|
| <b>平成26年度</b>  | <ul style="list-style-type: none"> <li>○ <u>第1回ワーキンググループ（平成26年8月）</u> <ul style="list-style-type: none"> <li>・今後の進め方について</li> <li>・到達目標・評価の在り方に関する論点について 等</li> </ul> </li> <li>○ <u>第2回ワーキンググループ（平成26年12月目途）</u> <ul style="list-style-type: none"> <li>・研究班<sup>*</sup>からの中間報告を踏まえ、さらなる論点の検討</li> <li>・平成27年臨床研修修了者アンケート調査内容の検討 等</li> </ul> </li> </ul> |
| <b>平成27年度</b>  | <ul style="list-style-type: none"> <li>○ <u>第3回ワーキンググループ（平成27年4月以降）</u> <ul style="list-style-type: none"> <li>・研究班からの最終報告等を踏まえ、ヒアリング等を行い、到達目標・評価の在り方について検討<br/>（以降、月に1度程度開催）</li> </ul> </li> </ul>   |
| <b>平成28年度中</b> | <ul style="list-style-type: none"> <li>・ワーキンググループにおけるとりまとめ</li> <li>・医師臨床研修部会に報告</li> </ul>  |
| <b>平成29年度～</b> | <ul style="list-style-type: none"> <li>・医師臨床研修部会にて審議</li> </ul>  |
| <b>平成32年度</b>  | <ul style="list-style-type: none"> <li>・見直しの適用</li> </ul>  |

※平成26年度厚生労働科学研究

「医師臨床研修の到達目標とその評価の在り方に関する研究」（研究代表者：福井次矢）

## 到達目標とその評価の在り方に関する研究について

以下の厚生労働科学研究において、到達目標及び評価の在り方の見直しに向けた検討の基礎資料として、どのような医師を育成すべきかを踏まえつつ、人口動態や疾病構造の変化、医療提供体制の変化、診療能力の評価、項目の簡素化、評価の標準化、医師養成全体の動向等の観点から、関係データの収集・分析を行う。

### ○平成26年度厚生労働科学研究「医師臨床研修の到達目標とその評価の在り方に関する研究」

研究代表者：福井次矢（聖路加国際病院 院長）

期間：平成26年4月1日～平成27年3月31日

研究概要：

#### 1. 診療能力を踏まえた到達目標設定の在り方に関する研究

- ・研修医の診療能力の実態や現在の目標の過不足および構成の問題点を把握するため、臨床研修指導医に対してインタビュー調査を行い、診療能力を踏まえた診療目標に関して、具体的な在り方と適用の妥当性について検討する。
- ・研修修了時に到達すべき能力を行動特性（コンピテンシー）として目標に設定することについて、国内外の資料等を参考に参考にする。

#### 2. 人口動態や疾病構造、医療提供体制の変化等を踏まえた到達目標の在り方に関する研究

- ・受療状況や入院・外来等についての疫学・保健統計等を用いて、入院、外来、在宅等において押さえるべき頻度の高い症候・手技・疾患等を検討する。
- ・臨床研修修了者アンケート調査結果を用いて、基本的診療能力と症例経験数について、過去のデータと比較・分析し、プログラム弾力化が研修医の基本的診療能力に与えた影響を調査する。

#### 3. 医師のプロフェッショナルリズムを踏まえた到達目標の在り方に関する研究

- ・臨床研修の基本理念に謳われる「医師としての人格の涵養」を具体化させるとの観点から、「プロフェッショナルリズム」を上記の「行動能力（コンピテンシー）」の一つととらえ、内外の取り組みについて情報を収集し、中間目標と研修方略の検討を行う。
- ・学会や民間のキャリア支援に関する取り組みについて情報収集を行い、それらを参考に、医師キャリア形成のあり方と体制の整備について検討を行う。

#### 4. 医師養成全体の動向を踏まえた到達目標の在り方に関する研究

- ・卒前教育にモデルコアカリキュラム、国家試験における出題基準、臨床研修における到達目標を比較可能な表を作成し、これらの連続性の観点から、臨床研修の到達目標について検討を行う。
- ・また、新たな専門医制度について情報を収集し、これへの連続性についても検討を行う。

#### 5. 到達目標の評価手法の標準化に関する研究

- ・評価手法や運用について実態を把握するため、プログラム責任者・臨床研修指導医および研修医等を対象としたアンケート等による調査を行い、評価手法の標準化や研修病院、研修医への適用のあり方について検討を行う。

## 到達目標・評価の在り方にかかる論点について

- 部会報告書において指摘された課題及び見直しの方向については参考資料2の通りであるが、ワーキンググループにおける検討の参考とするため、具体的な論点について、どのように考えるか。（以下の具体的な論点の例を参考）
- また、これ以外の論点について、どのようなものが考えられるか。

### 1. 到達目標にかかる論点について

（部会報告書の内容）

#### <課題>

- 到達目標は、臨床研修制度必修化以降、基本的にその内容は変更されていないが、
  - ・ 急速な高齢化等による人口動態や疾病構造の変化、卒前教育や新たな専門医の仕組み等の医師養成全体の動向等に配慮すべきである
  - ・ 症例レポートは入院患者について提出することとなっているが、化学療法や手術等は外来での対応が増加していること等の状況があることから、入院医療から外来医療への移行をはじめとした医療提供体制の変化等について、適切に踏まえるべきである
  - ・ 「経験すべき症状・病態・疾患」等については、当該項目を「経験する」ことが基本となっているが、診療能力の評価をさらに重視すべきである
  - ・ 項目が細分化されており、何らかの簡素化が必要である等の指摘がある。

#### <見直しの方向>

- 到達目標については、臨床研修制度施行以降、基本的にその内容は変更されていないが、人口動態や疾病構造の変化、医療提供体制の変化、診療能力の評価、項目の簡素化等の観点から、その内容を見直す必要がある。
- なお、到達目標や評価手法については、どのような医師を育成すべきかを踏まえた上で、医師養成全体の動向の中で、卒前教育のモデル・コア・カリキュラム、医師国家試験、新たな専門医の仕組みにおける各専門領域の目標等との連続性にも考慮しつつ、今次見直しではなく、次回見直しに向け、別途、臨床研修部会の下に検討の場を設けて見直すこととする。



## (具体的な論点の例)

### (1) 人口動態や疾病構造の変化

○ 2025年には団塊の世代が75歳以上となるなど、今後、ますます高齢化が進展することを踏まえ、高齢化の進展に伴う医療サービスの需要の増大に対応するため、例えば、以下のような患者像や医療現場に対応できる基本的な診療能力について、どのように考えるか。

- ・複数の慢性疾患等を有する患者への対応
- ・認知症を有する患者や疑われる患者への対応
- ・せん妄等の精神症状を合併した患者への対応
- ・リハビリテーションや胃ろう等の栄養管理が必要な患者への対応
- ・終末期医療が必要な患者への対応 等

○ 上記の他、臨床研修制度の導入時と比較して患者数の増加が見られ、将来専門とする分野にかかわらず初期の診療や専門医、保健サービスとの連携等が見込まれる疾病に対応するため、例えば、以下のような患者像や医療現場に対応できる基本的な診療能力について、どのように考えるか。

- ・悪性腫瘍等により緩和ケアが必要な患者への対応
- ・うつ病等の気分障害を有する患者や疑われる患者への対応 等

### (2) 医療提供体制の変化

○ 化学療法や手術等は外来での対応が増加していること等、入院医療から外来医療へ移行しているものに対応するため、症例レポートを外来患者も対象とすることについて、どのように考えるか。

○ 医療機能の分化や連携の推進、医療と介護の連携、地域包括ケアシステムの構築、精神病床の機能分化や長期入院精神障害者の地域移行等、現在進められている医療提供体制の整備状況を踏まえ、例えば、以下のような医療現場の経験について、どのように考えるか。

- ・入院医療の機能分化に伴い、退院後の生活を支え、また、地域包括ケアシステム※に資する在宅医療への対応
- ・自宅や施設など様々な場での看取りへの対応
- ・多様な医療、介護、保健サービス等を提供するための多職種協働への対応 等

※地域包括ケア：高齢者が住み慣れた地域でその有する能力に応じ自立した日常生活を営むことができるよう、医療、介護、予防、住まい、生活支援が包括的に提供される体制

### (3) 医師養成全体における連続性

- 卒前教育や医師国家試験との連続性の観点から、診療参加型臨床実習（クリニカル・クラークシップ）の実施状況や、大学間の取組内容の標準化等の状況を踏まえながら検討する必要があるのではないかと。
- 専門医については、日本専門医機構が、平成 29 年度からの養成開始を目指して認定基準の作成など準備を進めているが、これへの連続性の観点から、どのように考えるか。

### (4) 診療能力

- 「経験すべき症状・病態・疾患」等については、当該項目を「経験する」ことが基本となっているが、診療能力の評価をさらに重視するため、例えば、診療能力の習得の程度を示すことについて、どのように考えるか。
- 単に経験したか否かではなく、例えば、コンピテンシー（知識、技術、態度などを統合した能力であって、かつ、行動として観察できる能力）を踏まえた到達目標とする場合、留意すべきものについて、どのように考えるか。

### (5) 項目の簡素化

- 臨床研修をより効果的に実施する観点から、細分化された項目に関して、例えば、症状・病態・疾患について、必ず経験する項目とそれ以外の項目の在り方について、どのように考えるか。

## 2. 評価にかかる論点について

### (部会報告書の内容)

#### <課題>

- 評価手法が各研修病院によって異なっていることにより、臨床研修修了者の到達度に差異が生じる可能性がある。

#### <見直しの方向>

- 臨床研修の評価の在り方についても、各研修病院において採用している研修医の評価方法は様々であるため、何らかの標準化が必要である。
- なお、到達目標や評価手法については、どのような医師を育成すべきかを踏まえた上で、医師養成全体の動向の中で、卒前教育のモデル・コア・カリキュラム、医師国家試験、新たな専門医の仕組みにおける各専門領域の目標等との連続性にも考慮しつつ、今次見直しではなく、次回見直しに向け、別途、臨床研修部会の下に検討の場を設けて見直すこととする。(再掲)

(具体的な論点の例)

- 評価手法について何らかの標準化をするにあたって、例えば、以下のようなシステムを活用する際に留意すべき点について、どのように考えるか。
  - ・ EPOC\*の活用
  - ・ インターネットの活用 等

※Evaluation system of P0stgraduate Clinical training (オンライン卒後臨床研修評価システム)

- 研修期間中を通じて行う形成的評価について、例えば、ポートフォリオ評価を取り入れるとした場合、その運用に関して留意すべき点はあるか。

医師法第 16 条の 2 第 1 項に規定する臨床研修に関する省令の施行について(厚生労働省医政局長  
通知 平成 26 年 3 月 31 日)(別添 1)

## 臨床研修の到達目標

### 【到達目標】

#### I 行動目標

医療人として必要な基本姿勢・態度

#### II 経験目標

- A 経験すべき診察法・検査・手技
- B 経験すべき症状・病態・疾患
- C 特定の医療現場の経験

## 臨床研修の基本理念

臨床研修は、医師が、医師としての人格をかん養し、将来専門とする分野にかかわらず、医学及び医療の果たすべき社会的役割を認識しつつ、一般的な診療において頻繁に関わる負傷又は疾病に適切に対応できるよう、基本的な診療能力を身に付けることのできるものでなければならない。

## I 行動目標

### 医療人として必要な基本姿勢・態度

#### (1) 患者－医師関係

患者を全人的に理解し、患者・家族と良好な人間関係を確立するために、

- 1) 患者、家族のニーズを身体・心理・社会的側面から把握できる。
- 2) 医師、患者・家族がともに納得できる医療を行うためのインフォームド・コンセントが実施できる。
- 3) 守秘義務を果たし、プライバシーへの配慮ができる。

#### (2) チーム医療

医療チームの構成員としての役割を理解し、保健・医療・福祉の幅広い職種からなる他のメンバーと協調するために、

- 1) 指導医や専門医に適切なタイミングでコンサルテーションができる。
- 2) 上級及び同僚医師や他の医療従事者と適切なコミュニケーションがとれる。
- 3) 同僚及び後輩へ教育的配慮ができる。
- 4) 患者の転入・転出に当たり、情報を交換できる。
- 5) 関係機関や諸団体の担当者とコミュニケーションがとれる。

#### (3) 問題対応能力

患者の問題を把握し、問題対応型の思考を行い、生涯にわたる自己学習の習慣を身に付けるために、

- 1) 临床上の疑問点を解決するための情報を収集して評価し、当該患者への適応を判断できる（EBM =Evidence Based Medicineの実践ができる。）。
- 2) 自己評価及び第三者による評価を踏まえた問題対応能力の改善ができる。
- 3) 臨床研究や治験の意義を理解し、研究や学会活動に関心を持つ。
- 4) 自己管理能力を身に付け、生涯にわたり基本的診療能力の向上に努める。

#### (4) 安全管理

患者及び医療従事者にとって安全な医療を遂行し、安全管理の方策を身に付け、危機管理に参画するために、

- 1) 医療を行う際の安全確認の考え方を理解し、実施できる。
- 2) 医療事故防止及び事故後の対処について、マニュアルなどに沿って行動できる。
- 3) 院内感染対策（Standard Precautionsを含む。）を理解し、実施できる。

#### (5) 症例呈示

チーム医療の実践と自己の臨床能力向上に不可欠な、症例呈示と意見交換を行うために、

- 1) 症例呈示と討論ができる。
- 2) 臨床症例に関するカンファレンスや学術集会に参加する。

#### (6) 医療の社会性

医療の持つ社会的側面の重要性を理解し、社会に貢献するために、

- 1) 保健医療法規・制度を理解し、適切に行動できる。
- 2) 医療保険、公費負担医療を理解し、適切に診療できる。
- 3) 医の倫理、生命倫理について理解し、適切に行動できる。
- 4) 医薬品や医療用具による健康被害の発生防止について理解し、適切に行動できる。

## II 経験目標

### A 経験すべき診察法・検査・手技

#### (1) 医療面接

患者・家族との信頼関係を構築し、診断・治療に必要な情報が得られるような医療面接を実施するために、

- 1) 医療面接におけるコミュニケーションの持つ意義を理解し、コミュニケーションスキルを身に付け、患者の解釈モデル、受診動機、受療行動を把握できる。
- 2) 患者の病歴（主訴、現病歴、既往歴、家族歴、生活・職業歴、系統的レビュー）の聴取と記録ができる。
- 3) 患者・家族への適切な指示、指導ができる。

#### (2) 基本的な身体診察法

病態の正確な把握ができるよう、全身にわたる身体診察を系統的に実施し、記載するために、

- 1) 全身の観察（バイタルサインと精神状態の把握、皮膚や表在リンパ節の診察を含む。）ができ、記載できる。
- 2) 頭頸部の診察（眼瞼・結膜、眼底、外耳道、鼻腔口腔、咽頭の観察、甲状腺の触診を含む。）ができ、記載できる。
- 3) 胸部の診察（乳房の診察を含む。）ができ、記載できる。
- 4) 腹部の診察（直腸診を含む。）ができ、記載できる。
- 5) 泌尿・生殖器の診察（産婦人科的診察を含む。）ができ、記載できる。
- 6) 骨・関節・筋肉系の診察ができ、記載できる。
- 7) 神経学的診察ができ、記載できる。
- 8) 小児の診察（生理的所見と病的所見の鑑別を含む。）ができ、記載できる。
- 9) 精神面の診察ができ、記載できる。

#### (3) 基本的な臨床検査

病態と臨床経過を把握し、医療面接と身体診察から得られた情報をもとに必要な検査を、

- { **A**・・・自ら実施し、結果を解釈できる。  
その他・・・検査の適応が判断でき、結果の解釈ができる。

- 1) 一般尿検査（尿沈渣顕微鏡検査を含む。）
- 2) 便検査（潜血、虫卵）
- 3) 血算・白血球分画
- A**4) 血液型判定・交差適合試験
- A**5) 心電図（12誘導）、負荷心電図
- A**6) 動脈血ガス分析
- 7) 血液生化学的検査
  - ・簡易検査（血糖、電解質、尿素窒素など）
- 8) 血液免疫血清学的検査（免疫細胞検査、アレルギー検査を含む。）
- 9) 細菌学的検査・薬剤感受性検査
  - ・検体の採取（痰、尿、血液など）
  - ・簡単な細菌学的検査（グラム染色など）
- 10) 呼吸機能検査
  - ・スパイロメトリー
- 11) 髄液検査
- 12) 細胞診・病理組織検査
- 13) 内視鏡検査

- A)14) 超音波検査
- 15) 単純X線検査
- 16) 造影X線検査
- 17) X線CT検査
- 18) MRI検査
- 19) 核医学検査
- 20) 神経生理学的検査（脳波・筋電図など）

必修項目 下線の検査について経験があること

\* 「経験」とは受け持ち患者の検査として診療に活用すること  
 A)の検査で自ら実施する部分については、受け持ち症例でなくてもよい

#### (4) 基本的手技

基本的手技の適応を決定し、実施するために、

- 1) 気道確保を実施できる。
- 2) 人工呼吸を実施できる。(バッグ・バルブ・マスクによる徒手換気を含む。)
- 3) 胸骨圧迫を実施できる。
- 4) 圧迫止血法を実施できる。
- 5) 包帯法を実施できる。
- 6) 注射法（皮内、皮下、筋肉、点滴、静脈確保、中心静脈確保）を実施できる。
- 7) 採血法（静脈血、動脈血）を実施できる。
- 8) 穿刺法（腰椎）を実施できる。
- 9) 穿刺法（胸腔、腹腔）を実施できる。
- 10) 導尿法を実施できる。
- 11) ドレーン・チューブ類の管理ができる。
- 12) 胃管の挿入と管理ができる。
- 13) 局所麻酔法を実施できる。
- 14) 創部消毒とガーゼ交換を実施できる。
- 15) 簡単な切開・排膿を実施できる。
- 16) 皮膚縫合法を実施できる。
- 17) 軽度の外傷・熱傷の処置を実施できる。
- 18) 気管挿管を実施できる。
- 19) 除細動を実施できる。

必修項目 下線の手技を自ら行った経験があること

#### (5) 基本的治療法

基本的治療法の適応を決定し、適切に実施するために、

- 1) 療養指導（安静度、体位、食事、入浴、排泄、環境整備を含む。）ができる。
- 2) 薬物の作用、副作用、相互作用について理解し、薬物治療（抗菌薬、副腎皮質ステロイド薬、解熱薬、麻薬、血液製剤を含む。）ができる。
- 3) 基本的な輸液ができる。
- 4) 輸血（成分輸血を含む。）による効果と副作用について理解し、輸血が実施できる。



## (6) 医療記録

チーム医療や法規との関連で重要な医療記録を適切に作成し、管理するために、

- 1) 診療録（退院時サマリーを含む。）を POS (Problem Oriented System) に従って記載し管理できる。
- 2) 処方箋、指示箋を作成し、管理できる。
- 3) 診断書、死亡診断書、死体検案書その他の証明書を作成し、管理できる。
- 4) CPC（臨床病理検討会）レポートを作成し、症例呈示できる。
- 5) 紹介状と、紹介状への返信を作成でき、それを管理できる。

## (7) 診療計画

保健・医療・福祉の各側面に配慮しつつ、診療計画を作成し、評価するために、

- 1) 診療計画（診断、治療、患者・家族への説明を含む。）を作成できる。
- 2) 診療ガイドラインやクリティカルパスを理解し活用できる。
- 3) 入退院の適応を判断できる（デイサージャリー症例を含む。）。
- 4) QOL (Quality of Life) を考慮にいたった総合的な管理計画（リハビリテーション、社会復帰、在宅医療、介護を含む。）へ参画する。

### 必修項目

- 1) 診療録の作成
- 2) 処方箋・指示書の作成
- 3) 診断書の作成
- 4) 死亡診断書の作成
- 5) CPC レポート（※）の作成、症例呈示
- 6) 紹介状、返信の作成

上記 1) ～ 6) を自ら行った経験があること  
(※ CPC レポートとは、剖検報告のこと)

## B 経験すべき症状・病態・疾患

研修の最大の目的は、患者の呈する症状と身体所見、簡単な検査所見に基づいた鑑別診断、初期治療を的確に行う能力を獲得することにある。

### 1 頻度の高い症状

必修項目	<u>下線の症状</u> を経験し、レポートを提出する *「経験」とは、自ら診療し、鑑別診断を行うこと
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- 1) 全身倦怠感
- 2) 不眠
- 3) 食欲不振
- 4) 体重減少、体重増加
- 5) 浮腫
- 6) リンパ節腫脹
- 7) 発疹
- 8) 黄疸
- 9) 発熱
- 10) 頭痛
- 11) めまい
- 12) 失神
- 13) けいれん発作
- 14) 視力障害、視野狭窄
- 15) 結膜の充血
- 16) 聴覚障害
- 17) 鼻出血
- 18) 嘔声
- 19) 胸痛
- 20) 動悸
- 21) 呼吸困難
- 22) 咳・痰
- 23) 嘔気・嘔吐
- 24) 胸やけ
- 25) 嚥下困難
- 26) 腹痛
- 27) 便通異常 (下痢、便秘)
- 28) 腰痛
- 29) 関節痛
- 30) 歩行障害
- 31) 四肢のしびれ
- 32) 血尿
- 33) 排尿障害 (尿失禁・排尿困難)
- 34) 尿量異常
- 35) 不安・抑うつ

## 2 緊急を要する症状・病態

必修項目	<u>下線の病態</u> を経験すること *「経験」とは、初期治療に参加すること
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- 1) 心肺停止
- 2) ショック
- 3) 意識障害
- 4) 脳血管障害
- 5) 急性呼吸不全
- 6) 急性心不全
- 7) 急性冠症候群
- 8) 急性腹症
- 9) 急性消化管出血
- 10) 急性腎不全
- 11) 流・早産及び満期産
- 12) 急性感染症
- 13) 外傷
- 14) 急性中毒
- 15) 誤飲、誤嚥
- 16) 熱傷
- 17) 精神科領域の救急

### 3 経験が求められる疾患・病態

#### 必修項目

1. A疾患については入院患者を受け持ち、診断、検査、治療方針について症例レポートを提出すること
2. B疾患については、外来診療又は受け持ち入院患者（合併症含む。）で自ら経験すること
3. 外科症例（手術を含む。）を1例以上受け持ち、診断、検査、術後管理等について症例レポートを提出すること

※全疾患（88項目）のうち70%以上を経験することが望ましい

#### （1）血液・造血器・リンパ網内系疾患

- B①貧血（鉄欠乏性貧血、二次性貧血）
- ②白血病
- ③悪性リンパ腫
- ④出血傾向・紫斑病（播種性血管内凝固症候群：DIC）

#### （2）神経系疾患

- A①脳・脊髄血管障害（脳梗塞、脳内出血、くも膜下出血）
- ②認知症疾患
- ③脳・脊髄外傷（頭部外傷、急性硬膜外・硬膜下血腫）
- ④変性疾患（パーキンソン病）
- ⑤脳炎・髄膜炎

#### （3）皮膚系疾患

- B①湿疹・皮膚炎群（接触皮膚炎、アトピー性皮膚炎）
- B②蕁麻疹
- ③薬疹
- B④皮膚感染症

#### （4）運動器（筋骨格）系疾患

- B①骨折
- B②関節・靭帯の損傷及び障害
- B③骨粗鬆症
- B④脊柱障害（腰椎椎間板ヘルニア）

#### （5）循環器系疾患

- A①心不全
- B②狭心症、心筋梗塞
- ③心筋症
- B④不整脈（主要な頻脈性、徐脈性不整脈）
- ⑤弁膜症（僧帽弁膜症、大動脈弁膜症）
- B⑥動脈疾患（動脈硬化症、大動脈瘤）
- ⑦静脈・リンパ管疾患（深部静脈血栓症、下肢静脈瘤、リンパ浮腫）
- A⑧高血圧症（本態性、二次性高血圧症）

## (6) 呼吸器系疾患

- B①呼吸不全
- A②呼吸器感染症（急性上気道炎、気管支炎、肺炎）
- B③閉塞性・拘束性肺疾患（気管支喘息、気管支拡張症）
  - ④肺循環障害（肺塞栓・肺梗塞）
  - ⑤異常呼吸（過換気症候群）
  - ⑥胸膜、縦隔、横隔膜疾患（自然気胸、胸膜炎）
  - ⑦肺癌

## (7) 消化器系疾患

- A①食道・胃・十二指腸疾患（食道静脈瘤、胃癌、消化性潰瘍、胃・十二指腸炎）
- B②小腸・大腸疾患（イレウス、急性虫垂炎、痔核・痔瘻）
  - ③胆嚢・胆管疾患（胆石症、胆嚢炎、胆管炎）
- B④肝疾患（ウイルス性肝炎、急性・慢性肝炎、肝硬変、肝癌、アルコール性肝障害、薬物性肝障害）
  - ⑤膵臓疾患（急性・慢性膵炎）
- B⑥横隔膜・腹壁・腹膜（腹膜炎、急性腹症、ヘルニア）

## (8) 腎・尿路系（体液・電解質バランスを含む。）疾患

- A①腎不全（急性・慢性腎不全、透析）
  - ②原発性糸球体疾患（急性・慢性糸球体腎炎症候群、ネフローゼ症候群）
  - ③全身性疾患による腎障害（糖尿病性腎症）
- B④泌尿器科的腎・尿路疾患（尿路結石症、尿路感染症）

## (9) 妊娠分娩と生殖器疾患

- B①妊娠分娩（正常妊娠、流産、早産、正常分娩、産科出血、乳腺炎、産褥）
  - ②女性生殖器及びその関連疾患（月経異常（無月経を含む。）、不正性器出血、更年期障害、外陰・膣・骨盤内感染症、骨盤内腫瘍、乳腺腫瘍）
- B③男性生殖器疾患（前立腺疾患、勃起障害、精巣腫瘍）

## (10) 内分泌・栄養・代謝系疾患

- ①視床下部・下垂体疾患（下垂体機能障害）
- ②甲状腺疾患（甲状腺機能亢進症、甲状腺機能低下症）
- ③副腎不全
- A④糖代謝異常（糖尿病、糖尿病の合併症、低血糖）
- B⑤高脂血症
- ⑥蛋白及び核酸代謝異常（高尿酸血症）

## (11) 眼・視覚系疾患

- B①屈折異常（近視、遠視、乱視）
- B②角結膜炎
- B③白内障
- B④緑内障
- ⑤糖尿病、高血圧・動脈硬化による眼底変化

## (12) 耳鼻・咽喉・口腔系疾患

- B①中耳炎
  - ②急性・慢性副鼻腔炎
- B③アレルギー性鼻炎
  - ④扁桃の急性・慢性炎症性疾患
  - ⑤外耳道・鼻腔・咽頭・喉頭・食道の代表的な異物

### (13) 精神・神経系疾患

- ①症状精神病
- A②認知症（血管性認知症を含む。）
- ③アルコール依存症
- A④気分障害（うつ病、躁うつ病を含む。）
- A⑤統合失調症
- ⑥不安障害（パニック障害）
- B⑦身体表現性障害、ストレス関連障害

### (14) 感染症

- B①ウイルス感染症（インフルエンザ、麻疹、風疹、水痘、ヘルペス、流行性耳下腺炎）
- B②細菌感染症（ブドウ球菌、MRSA、A群レンサ球菌、クラミジア）
- B③結核
- ④真菌感染症（カンジダ症）
- ⑤性感染症
- ⑥寄生虫疾患

### (15) 免疫・アレルギー疾患

- ①全身性エリテマトーデスとその合併症
- B②関節リウマチ
- B③アレルギー疾患

### (16) 物理・化学的因子による疾患

- ①中毒（アルコール、薬物）
- ②アナフィラキシー
- ③環境要因による疾患（熱中症、寒冷による障害）
- B④熱傷

### (17) 小児疾患

- B①小児けいれん性疾患
- B②小児ウイルス感染症（麻疹、流行性耳下腺炎、水痘、突発性発疹、インフルエンザ）
- ③小児細菌感染症
- B④小児喘息
- ⑤先天性心疾患

### (18) 加齢と老化

- B①高齢者の栄養摂取障害
- B②老年症候群（誤嚥、転倒、失禁、褥瘡）

## C 特定の医療現場の経験

必修項目にある現場の経験とは、各現場における到達目標の項目のうち一つ以上経験すること。

### (1) 救急医療

生命や機能的予後に係わる、緊急を要する病態や疾病、外傷に対して適切な対応をするために、

- 1) バイタルサインの把握ができる。
- 2) 重症度及び緊急度の把握ができる。
- 3) ショックの診断と治療ができる。
- 4) 二次救命処置 (ACLS = Advanced Cardiovascular Life Support、呼吸・循環管理を含む。)が、一次救命処置 (BLS = Basic Life Support) を指導できる。  
※ ACLS は、バッグ・バルブ・マスク等を使う心肺蘇生法や除細動、気管挿管、薬剤投与等の一定のガイドラインに基づく救命処置を含み、BLS には、気道確保、胸骨圧迫、人工呼吸等機器を使用しない処置が含まれる。
- 5) 頻度の高い救急疾患の初期治療ができる。
- 6) 専門医への適切なコンサルテーションができる。
- 7) 大災害時の救急医療体制を理解し、自己の役割を把握できる。

必修項目 救急医療の現場を経験すること

### (2) 予防医療

予防医療の理念を理解し、地域や臨床の場での実践に参画するために、

- 1) 食事・運動・休養・飲酒・禁煙指導とストレスマネジメントができる。
- 2) 性感染症予防、家族計画を指導できる。
- 3) 地域・産業・学校保健事業に参画できる。
- 4) 予防接種を実施できる。

必修項目 予防医療の現場を経験すること

### (3) 地域医療

地域医療を必要とする患者とその家族に対して、全人的に対応するために、

- 1) 患者が営む日常生活や居住する地域の特性に即した医療 (在宅医療を含む) について理解し、実践する。
- 2) 診療所の役割 (病診連携への理解を含む。) について理解し、実践する。
- 3) へき地・離島医療について理解し、実践する。

必修項目

へき地・離島診療所、中小病院・診療所等の地域医療の現場を経験すること

#### (4) 周産・小児・成育医療

周産・小児・成育医療を必要とする患者とその家族に対して、全人的に対応するために、

- 1) 周産期や小児の各発達段階に応じて適切な医療が提供できる。
- 2) 周産期や小児の各発達段階に応じて心理社会的側面への配慮ができる。
- 3) 虐待について説明できる。
- 4) 学校、家庭、職場環境に配慮し、地域との連携に参画できる。
- 5) 母子健康手帳を理解し活用できる。

必修項目	周産・小児・成育医療の現場を経験すること
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#### (5) 精神保健・医療

精神保健・医療を必要とする患者とその家族に対して、全人的に対応するために、

- 1) 精神症状の捉え方の基本を身につける。
- 2) 精神疾患に対する初期的対応と治療の実際を学ぶ。
- 3) デイケアなどの社会復帰や地域支援体制を理解する。

必修項目	精神保健福祉センター、精神科病院等の精神保健・医療の現場を経験すること
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#### (6) 緩和ケア、終末期医療

緩和ケアや終末期医療を必要とする患者とその家族に対して、全人的に対応するために、

- 1) 心理社会的側面への配慮ができる。
- 2) 治療の初期段階から基本的な緩和ケア（WHO方式がん疼痛治療法を含む。）ができる。
- 3) 告知をめぐる諸問題への配慮ができる。
- 4) 死生観・宗教観などへの配慮ができる。

必修項目	臨終の立ち会いを経験すること
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#### (7) 地域保健

地域保健を必要とする患者とその家族に対して、全人的に対応するために、保健所、介護老人保健施設、社会福祉施設、赤十字社血液センター、各種検診・健診の実施施設等の地域保健の現場において、

- 1) 保健所の役割（地域保健・健康増進への理解を含む。）について理解し、実践する。
- 2) 社会福祉施設等の役割について理解し、実践する。



医道審議会医師分科会医師臨床研修部会 報告書（平成25年12月19日）  
（抜粋）

1. 基本理念と到達目標について

2) 到達目標とその評価

<現状>

（到達目標）

- 施行通知において、「臨床研修の目標」は、「臨床研修の到達目標」を参考にして、研修病院が当該研修プログラムにおいて研修医の到達すべき目標として作成するものであり、「臨床研修の到達目標」を達成できる内容であることとされている。
- 「臨床研修の到達目標」は、Ⅰ行動目標（医療人として必要な基本姿勢・態度）、Ⅱ経験目標（A 経験すべき診察法・検査・手技、B 経験すべき症状・病態・疾患、C 特定の医療現場の経験）により構成されている。

（評価方法）

- 大学病院及び研修病院において、採用している研修医の評価方法は様々であり、「指導医による評価」「症例レポート」「コメディカルによる評価」の順に多く、「口頭試問」「実技試験（OSCE）」「患者による評価」等は少ない。
- 米国、英国、仏国の臨床研修制度においては、研修医、指導医、研修プログラムに対する評価が多角的に行われており、特に英国はインターネット（e-ポートフォリオ等）の活用が進んでいる。

<課題>

- 到達目標は、臨床研修制度必修化以降、基本的にその内容は変更されていないが、
    - ・ 急速な高齢化等による人口動態や疾病構造の変化、卒前教育や新たな専門医の仕組み等の医師養成全体の動向等に配慮すべきである
    - ・ 症例レポートは入院患者について提出することとなっているが、化学療法や手術等は外来での対応が増加していること等の状況があることから、入院医療から外来医療への移行をはじめとした医療提供体制の変化等について、適切に踏まえるべきである
    - ・ 「経験すべき症状・病態・疾患」等については、当該項目を「経験する」ことが基本となっているが、診療能力の評価をさらに重視すべきである
    - ・ 項目が細分化されており、何らかの簡素化が必要である
- 等の指摘がある。

- 評価手法が各研修病院によって異なっていることにより、臨床研修修了者の到達度に差異が生じる可能性がある。

#### <見直しの方向>

- 到達目標については、臨床研修制度施行以降、基本的にその内容は変更されていないが、人口動態や疾病構造の変化、医療提供体制の変化、診療能力の評価、項目の簡素化等の観点から、その内容を見直す必要がある。
- 臨床研修の評価の在り方についても、各研修病院において採用している研修医の評価方法は様々であるため、何らかの標準化が必要である。
- なお、到達目標や評価手法については、どのような医師を育成すべきかを踏まえた上で、医師養成全体の動向の中で、卒前教育のモデル・コア・カリキュラム、医師国家試験、新たな専門医の仕組みにおける各専門領域の目標等との連続性にも考慮しつつ、今次見直しではなく、次回見直しに向け、別途、臨床研修部会の下に検討の場を設けて見直すこととする。

## 4. その他

### 2) 医師養成全体との関係

#### <現状>

(卒前教育)

- 卒前教育に関しては、文部科学省において、平成 12 年度に学生が卒業までに最低限履修すべき実践的診療能力（知識・技能・態度）に関する指針（モデル・コア・カリキュラム）が定められ、平成 19 年度及び平成 22 年度の改訂を経て、全ての大学において利用されている。
- 平成 17 年度より、学生が臨床実習開始前に備えるべき能力を測定する共通の標準的評価試験である共用試験（CBT（知識）、OSCE（技能））が全面導入され、全大学において実施されている。大半の大学において共用試験を進級要件として利用しているが、合格基準は大学により異なることが課題である。
- 現状では、大部分の大学において、臨床実習は5年次から6年次の夏頃まで実施されているものの、その実施期間は大学により幅があり、学生が診療に参加する診療参加型臨床実習（クリニカル・クラークシップ）、学外の病院での実習等、臨床実習の内容の充実についても課題であるが、量・質ともに改善していく動きがある。
- 全ての大学で診療参加型臨床実習が行われているが、国際的な質保証の動きも踏まえつつ、質的により充実した実習を実施していくことが課題となっている。
- 各大学で、地域医療に関する講座等を活用し、地域医療に関する教育が行われている。

- 卒業前 OSCE を実施する大学も増加する傾向であり、現在、半数以上の大学が卒業前に実施しており、全体の 4 分の 1 程度が卒業認定に用いている。

(医師国家試験)

- 医師国家試験については、医師国家試験改善検討部会報告書（平成 23 年 6 月）を踏まえ、卒前教育・臨床研修を含めた一連の医師養成課程に配慮しつつ、出題の検討が行われているところである。

(新たな専門医に関する仕組み)

- 臨床研修修了後の医師の専門研修については、平成 25 年 4 月に、厚生労働省の「専門医の在り方に関する検討会」が報告書を取りまとめたところであり、専門医の質を高め、良質な医療が提供されることを目的に、新たな専門医の仕組みが構築され、学会から独立した中立的な第三者機関により専門医の認定・更新や養成プログラムの評価・認定を統一的に行い、平成 29 年度を目途に、新たな養成プログラムに基づき専門医の養成が開始される予定である。

#### <課題>

- 臨床研修制度のあり方については、卒前教育や、新たな専門医の仕組みの動向を踏まえ、検討していく必要がある。
- 卒前教育において、診療参加型臨床実習（クリニカル・クラークシップ）が充実され、大学間の取組内容の標準化等がさらに進めば、臨床研修に関する期間も含めて所要の見直しもあり得るといふ指摘がある一方、医師免許の取得前後では医療現場における責任が異なるため、卒前教育の充実と臨床研修の見直しについては慎重な対応が必要であるという指摘もある。

#### <見直しの方向>

- 臨床研修制度のあり方については、どのような医師を育成すべきかを踏まえた上で、卒前教育における診療参加型臨床実習（クリニカル・クラークシップ）の充実や大学間の取組内容の標準化等の状況や、新たな専門医の仕組みの検討状況を踏まえつつ、卒前教育、国家試験、専門研修、生涯教育との連続性の観点から、総合的に検討を続けていくべきである。
- 特に、卒前教育の充実に伴う臨床研修制度の見直しについては、今後も卒前教育の動向等を注視し、十分な検討が望まれる。
- また、国家試験についても、上記の動向を踏まえつつ、今後の検討がなされることが望まれる。

## おわりに

- 今後、本報告書をもとに、制度の一層の向上が図られることを期待したい。

- あわせて、引き続き、臨床研修制度の在り方については、基本理念に照らし、関係の状況を十分に踏まえつつ、必要な検討を行っていく必要があり、今回の制度見直しの施行後5年以内に所要の見直しを行うことが求められる。
- 検討に際しては、どのような医師を育成すべきかを踏まえた上で、卒前教育、国家試験、専門研修、生涯教育との連続性の観点を十分に考慮すべきである。
- なお、次回の制度見直しに向けての検討事項とした到達目標及び評価の在り方等については、本報告書をもとに速やかな検討が望まれる。

(別添1)

## 医道審議会医師分科会医師臨床研修部会委員名簿

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おしづち 押淵	とおる 徹 国民健康保険平戸市民病院長
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よしおか 吉岡	あきら 章 奈良県立医科大学長

○印は部会長

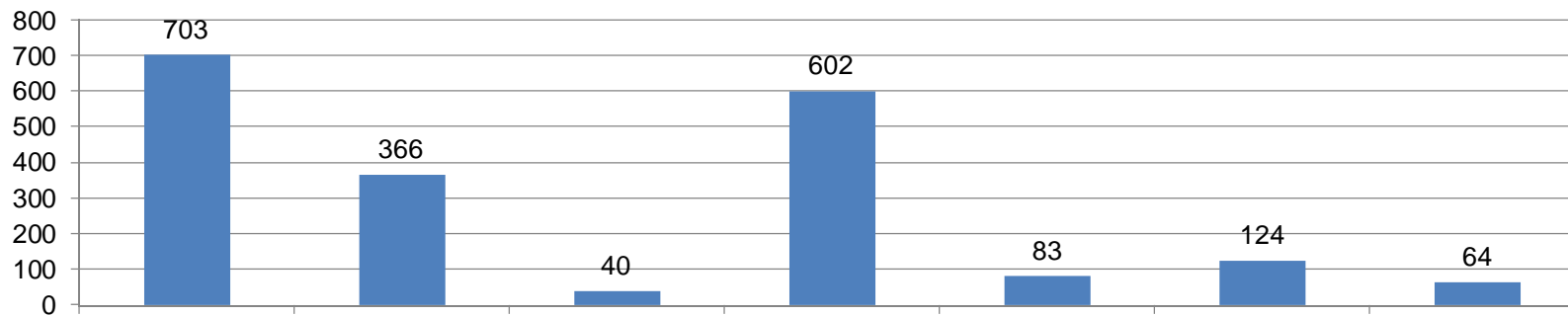
(五十音順)

# 各病院で採用している研修医の評価方法

出典：平成24年度厚生労働科学研究「医師臨床研修制度の評価と医師のキャリアパスの動向に関する調査研究」  
分担研究者 片岡 仁美（岡山大学教授）

## 【臨床研修の評価について】

採用している評価方法(n=1,982 複数回答可)



1 指導医による評価(観察記録、面談、チェックリスト等)

2 コメディカルによる評価(観察記録、チェックリスト等)

3 患者による評価

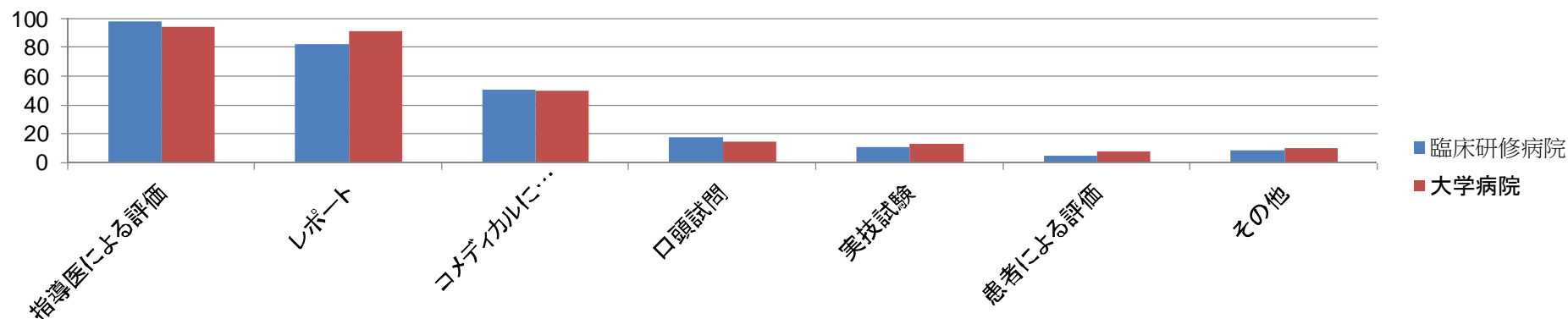
4 レポート

5 実技試験(OSCE)

6 口頭試問

7 その他

(参考)採用している評価方法についてカテゴリ別に評価<研修病院の種別(臨床研修病院n=612 大学病院n=91)>



諸外国の臨床研修制度について(概要)

出典：平成24年度厚生労働科学研究「医師臨床研修制度の評価と医師のキャリアパスの

※指導医、研修プログラムに対する評価も同様に存在。 動向に関する調査研究」分担研究者 大滝 純司（北海道大学教授）

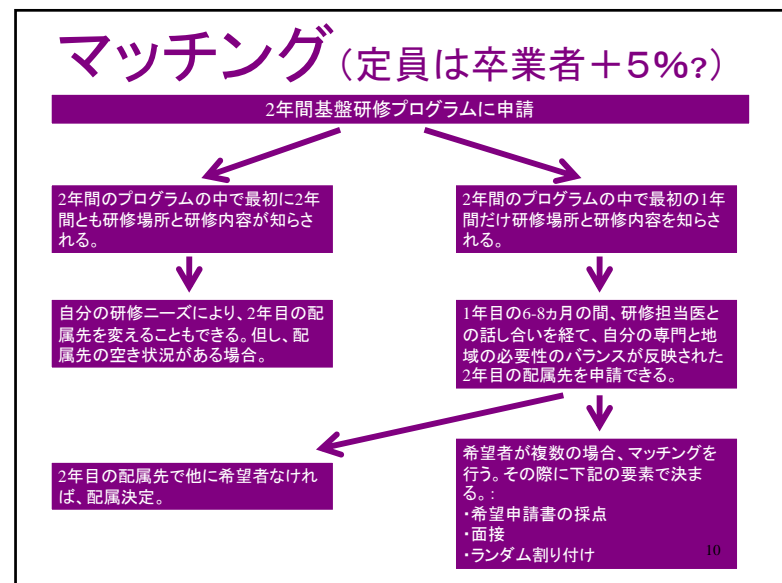
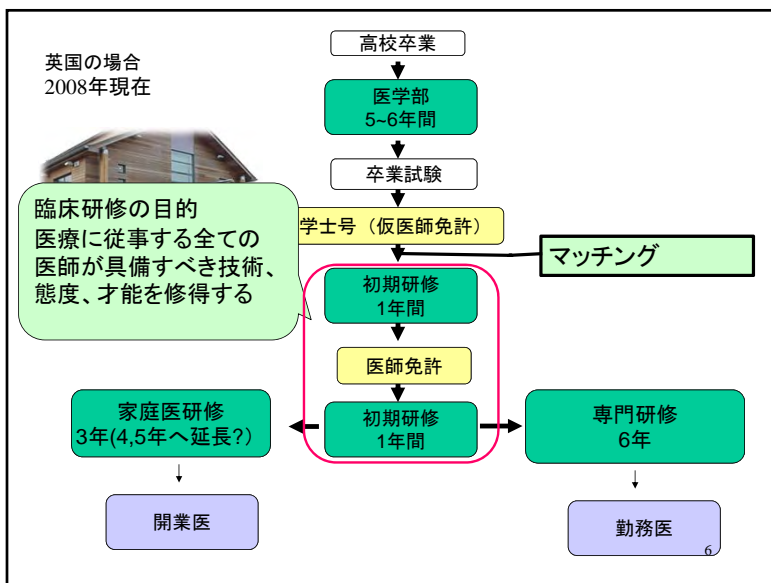
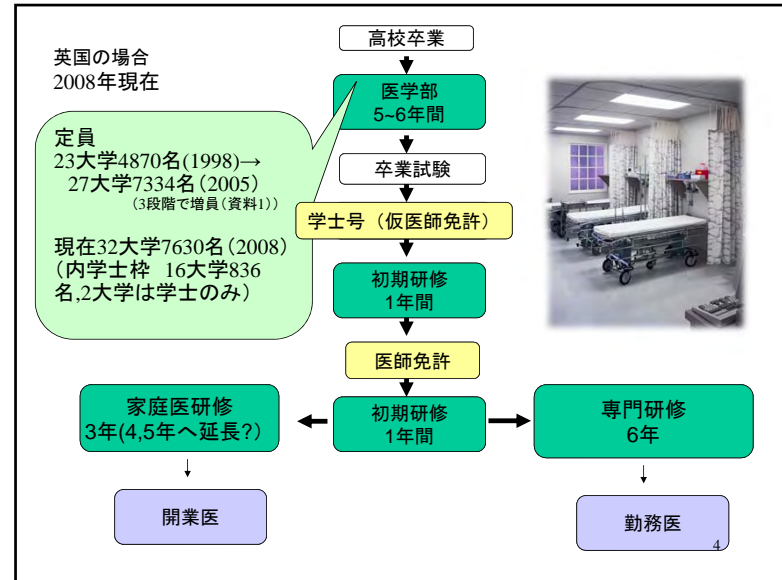
		米国	英国	仏国
研修医に対する評価	時期・頻度	毎月 ローテーション終了時	ローテーション開始時・終了時 1年目終了時	研修期間終了時(6ヶ月毎)
	項目	コンピテンシー： 患者ケア・医学的知識・臨床に即した学習 & 向上・対人 & コミュニケーションスキル・プロフェッショナルリズム・システムに基づいた診療	問診・診察能力・診断・治療に関するアウトカム評価 コンピテンシー到達度(診療、安全管理・最善の医療の提供・教育・医師患者関係の構築・コミュニケーション・チーム医療・プロフェッショナルリズム) 試験無	勤務状況、態度の他、基本知識、診断能力、治療能力、コミュニケーション、患者教育、知的好奇心等
	方法	Web上で9段階評価 コメント欄には必ず何かを記載しないと保存送信できない	Supervised learning event(「指導医による直接観察(診察技能および手技)」「事例検討」「指導と症例提示」の三項目について指導医が立ち会い評価)	評価用紙
	評価担当者	アテンディング(上級指導医)/同僚/ シニアレジデント	指導医とプログラム責任者	科のチーフが評価担当者、シニアドクター、チーフ看護師と話し合っ
	FB(フィードバック)や判定の仕組み	プログラムディレクターが評価点をもとに、2回/年の面接時にフィードバック	指導医からの直接フィードバック 到達程度が不十分の場合、追加のトレーニングの提供	記入済評価用紙を研修医の大学、健康省の地方自治体へ送る
	指導や介入	プログラムディレクターやチーフレジデントによる個別面談時に指導	直接指導や追加トレーニングの提供	問題により、研修医組合、健康省の地方自治体へ報告
	罰則や不利益処分	評価が悪い場合 2年目から3年目へ進めない	1年間の評価が低いと留年/2年目の研修先選択に不利に。2年間で必要条件が不十分では研修修了とならず、専門プログラムへ進めない。	研修の無効(再チャンスのあるとは限らない)
	苦情や意見の匿名受付	内科研修プログラムHP上研修医が匿名で意見や苦情投稿可。プログラムディレクターとチーフレジデントが1回/週見直して会議を行っている。	E-portfolio上でのプログラムに対する評価は指導医に見られず、研修施設の責任者へメールされる仕組み 患者からの苦情も受ける	無 1部署に最高6名の研修医のため匿名性は保てない
	実施可能な医療行為	指導医の監督下 施設や州により特定の制限有	指導医の監督下 研修を受けた範囲でのみ診療可能	

## イギリス編(2008)

- 国民皆保険
- 総合医+専門医の2段階制
- 入学定員増(1.5倍)
- 基本研修1年+専門準備研修1年
- 地域マッチング
- 大学と病院の連携研修

人口 6,000万人、医師 2.4/人口1,000人  
看護師 9.1/人口1,000人

人口 127,300万人、医師 2.0/人口1,000人  
看護師 9.0/人口1,000人





# プログラム実例

2年通しの例 (OXFORD)

番号	F1			F2		
	36	外科:大腸、血管、乳腺、泌尿器(B)	内科:リウマチ、消化器 (B)		家庭医	精神 (Warneford)
37	内科:リウマチ、消化器 (B)		外科:大腸、血管、乳腺、泌尿器(B)	心臓外科 (JRH)	家庭医	精神 (Warneford)
38	外科 (JRH)	内科 (JRH)	小児外科 (JRH)	救急	外傷外科	老年内科
39	小児外科 (JRH)	外科 (JRH)	内科 (JRH)	外傷外科	老年内科	救急

- 原則 4ヶ月を単位として年間 3ローテ
- F1: 内科+外科+選択(65種類) が一般的
- F2: 将来の専門を視野に選択? (家庭医、不足分野、アカデミックを推奨?)  
10日以上30日以内の勉強目的の休止期間をとり、蘇生講習、他の専門等研修

# 研修目標

1. Good Clinical Care (cont.)		8. Practical Procedures	
Competence	Assessment tool	Competence	Assessment tools
(i) Educating patients about disease prevention, investigations and therapy	Mini-CEX/CbD	F1 Procedures that F1 doctors should be competent and confident to do and teach to undergraduates:	DOPS
(ii) Environmental, biological and lifestyle risk factors	Mini-CEX/CbD		
(iii) Smoking	Mini-CEX/CbD		
(iv) Alcohol	Mini-CEX/CbD		
(v) Epidemiology and screening	Mini-CEX/CbD		
		<ul style="list-style-type: none"> <li>• venepuncture and IV cannulation</li> <li>• local anaesthetics</li> <li>• arterial puncture in an adult</li> <li>• blood cultures from peripheral and central sites</li> <li>• subcutaneous, intradermal, intramuscular and intravenous injections</li> <li>• IV medications</li> <li>• intravenous infusions, including the prescription of fluids, blood and blood products</li> <li>• ECG</li> <li>• spirometry and peak flow</li> <li>• urethral catheterisation</li> <li>• airway care, including simple adjuncts</li> <li>• nasogastric tube insertion.</li> </ul>	
		<p>During F2, doctors are expected to maintain and improve their skills in the above procedures. By the end of the year they should be able to help others with difficult procedures and guide F1 doctors in teaching others. Foundation doctors will be able to extend the range of procedures they can do. Each speciality will specify an appropriate range of procedures in which foundation doctors will be expected to become proficient, e.g.</p> <ul style="list-style-type: none"> <li>• aspiration of pleural fluid or air</li> <li>• skin suturing</li> <li>• lumbar puncture</li> <li>• insertion of a central venous pressure line</li> <li>• aspiration of joint effusion.</li> </ul>	DOPS
			15

喫煙指導、禁酒指導などの行動目標が主体

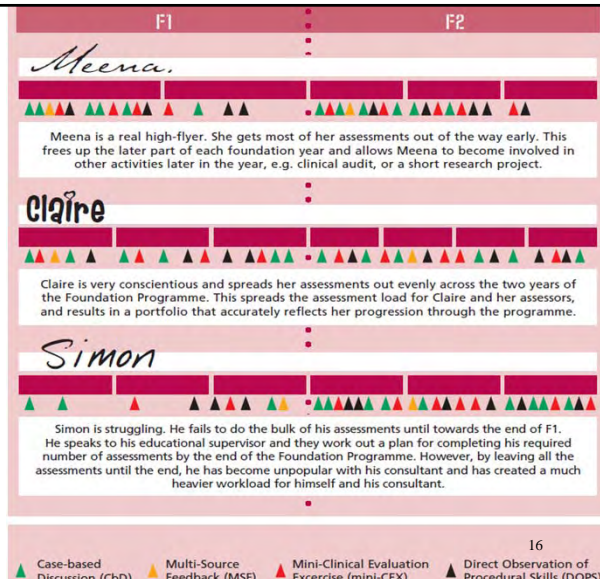
基本手技もF1とF2に分かれている

例 F1 局所麻酔  
F2 中心静脈穿刺

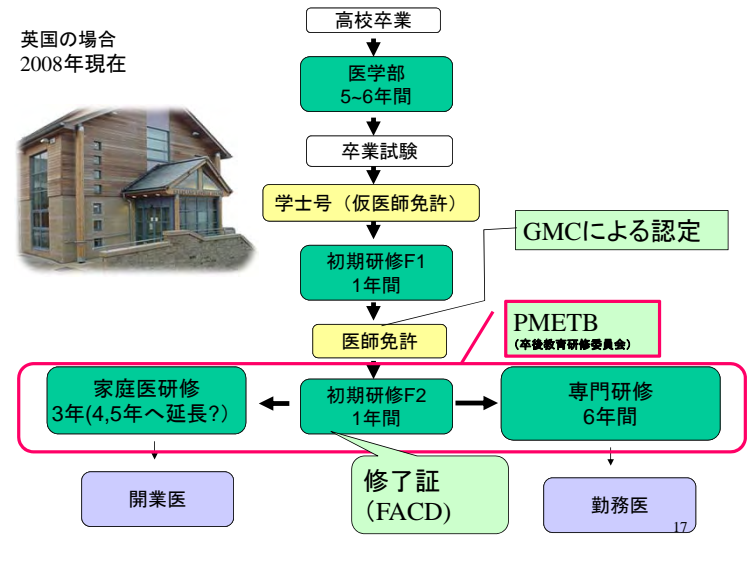
経験すべき疾患は定められていない

# 評価

研修医が指導医にローテーション毎に評価を求め、ポートフォリオをつくり、F1終了時に地区責任者に提出する

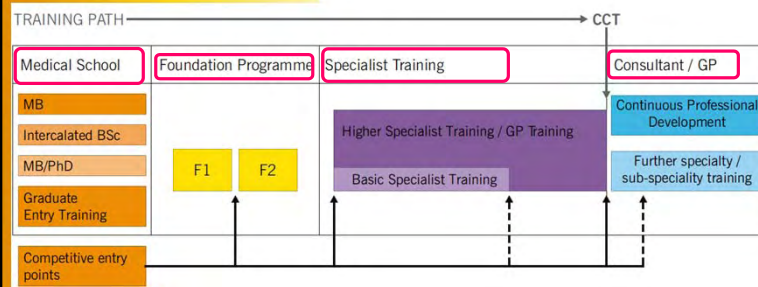


英国の場合  
2008年現在



# 英国の研修医制度

18



Report of the Academic Careers Sub-Committee of  
Modernising Medical Careers and the  
UK Clinical Research Collaboration  
March 2005

<http://www.nccrcd.nhs.uk/> 18

# 英国の研修医制度

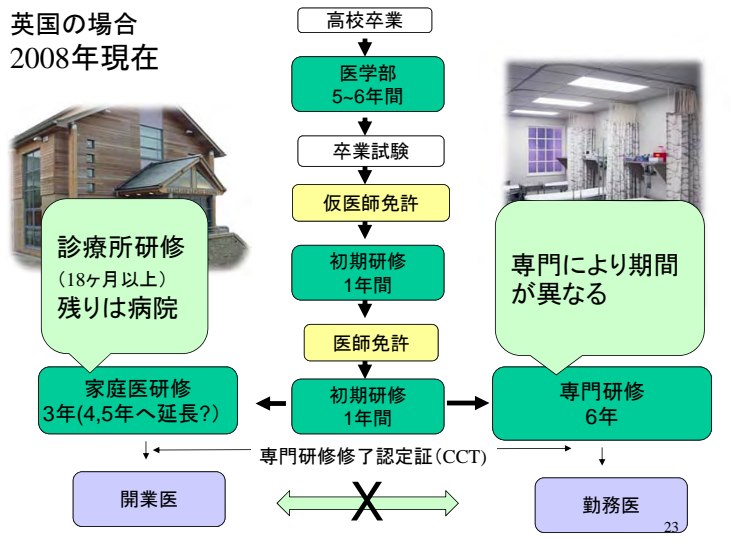


英国の臨床研修には“種芋”育成コースが設置された  
診療する傍ら研究を行う

Modernising Medical Careers and the  
UK Clinical Research Collaboration  
March 2005

<http://www.nccrcd.nhs.uk/> 20

## 英国の場合 2008年現在



The UK  
**Foundation  
Programme  
Curriculum**



This document has  
been updated for  
August 2014  
as approved by  
the GMC on  
4 March 2014

July 2012



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# Preface

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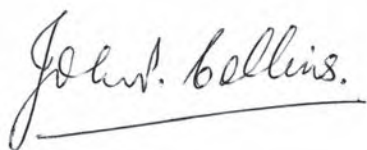
The Academy of Medical Royal Colleges is to be congratulated on the timely revision of this curriculum in response to the findings and recommendations contained in my report on the review of the Foundation Programme.

The purpose of the Foundation Programme, the outcomes expected and the step-up required from foundation year 1 (F1) to foundation year 2 (F2) are clearly articulated. This will provide foundation doctors, their teachers and supervisors, other healthcare professionals and employers with a clear direction on what is necessary for the programme to achieve its important learning objectives.

New emphasis has been placed on the whole patient, on long-term conditions and the increasing role of community care. Recognition of the workplace as providing the majority of clinical and professional learning opportunities is an important message for learners. Acknowledgement of the significance of adopting new technologies which support learning is welcomed.

The modifications to assessment are a major advance. Workplace-based assessment has been changed to provide opportunities for supervised learning events and immediate feedback rather than acting as a component of overall assessment. The revised use of these tools is a positive response to submissions made by foundation doctors and supervisors on assessment.

I welcome this revised and comprehensive curriculum and support its implementation.

A handwritten signature in black ink that reads "John Collins." The signature is written in a cursive style and is underlined with a single horizontal line.

Professor John Collins  
Nuffield Department of Surgical Sciences  
University of Oxford  
Chair of Review of the Foundation Programme

# Executive summary

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The *Foundation Programme Curriculum 2012* (the Curriculum) sets out the framework for educational progression that will support the first two years of professional development following graduation from medical school.

## Good medical practice and the foundation doctor

The Curriculum is based on the General Medical Council's (GMC) documents *Good Medical Practice* (2006) (GMP) and *The Trainee Doctor* (2011) (TTD). The Curriculum builds naturally on the competences, attitudes and behaviours acquired during undergraduate training based around *Tomorrow's Doctors* (2009). All foundation doctors and trainers are expected to be familiar with GMP and TTD and to follow the guidance contained therein on the principles and standards of clinical care, competence and conduct.

The UK Foundation Programme Office's (UKFPO's) companion document, the *Foundation Programme Reference Guide* (2012) (the Reference Guide) provides guidance to deaneries and foundation schools about the structures and systems required to support the delivery of the Curriculum.

## Outcomes of foundation training

Satisfactory completion of foundation year 1 (F1) will satisfy the needs of the GMC, making the foundation doctor eligible to apply for full registration. Satisfactory performance in foundation year 2 (F2) will lead to the award of a Foundation Achievement of Competence Document (FACD) which will indicate that the foundation doctor is ready to enter a core, specialty or general practice training programme.

## Who should use the Curriculum

The Curriculum is intended to be used by foundation doctors, deliverers of their education and those responsible for quality assurance (nationally), quality management (deanery) and quality control (locally). It is also intended to inform medical schools of the outcomes and competences required by foundation doctors. Some areas of the document are more appropriate to particular groups, for example, the *Syllabus* is particularly relevant for foundation doctors and their supervisors.

*It is highly recommended that the section [How to use the Curriculum](#) is read thoroughly by all.*

## Key messages of the Curriculum

The purpose of foundation training is clearly stated and is underpinned by two central concepts:

- **Patient safety**

Patient safety must be put at the centre of healthcare and depends both on individual practice and also effective multidisciplinary team working

- **Personal development**

Throughout their careers, doctors should strive to improve their performance to ensure their progression from competent, through proficient to expert, with the aspiration always to provide the highest possible quality of healthcare.

# Executive summary

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Foundation doctors must continuously work to improve performance. They are expected to develop critical thinking and professional judgement, especially where there is clinical uncertainty. Foundation doctors should regularly reflect on what they perform well and which aspects of performance could be improved in order to develop skills, understanding and clinical acumen.

## Learning opportunities in foundation

Doctors are committed to life-long learning and continuing professional development. Learning in and from the practice of medicine through repeated clinical experience is the most effective way for professionals to develop their expertise.

Learning is best achieved when there is frequent observation of practice in the workplace with immediate feedback on performance from a senior clinician. Every clinical experience is a learning opportunity whether it occurs during ward rounds, in clinics, in primary care settings, on call, during procedures etc. Interaction between the foundation doctor and trainer during supervised learning events (SLEs) should lead to reflection and further targets for development. Foundation doctors and trainers should work to maximise the opportunities for SLEs both as unscheduled, opportunistic events and also arranged in advance with a specific focus. The feedback should be recorded contemporaneously in the foundation doctor's e-portfolio.

During the two year programme, foundation doctors will increasingly be able to work adaptively in healthcare teams to manage acutely ill patients as well as those with long-term conditions. Competences in the syllabus should be acquired in a variety of clinical settings. Some competences are achieved most readily in the context of specific placements; for example, those competences relating to long-term care are usually best experienced in community based placements. The UK health service is moving towards delivering more care in the community and this will require foundation doctors to increasingly gain experience of and demonstrate competences within community placements. Many rotations already have placements which allow for the experience of caring for patients with long-term diseases in the community and it is anticipated that the availability of community placements will increase. Foundation doctors should also learn about management of patients with long-term conditions by involvement in inpatient and outpatient care and meticulous discharge planning. This will further develop their understanding of long-term care in the community.

Whatever the rotation, foundation doctors should ascertain what specific learning opportunities are available in each placement.

## Assessment during foundation training

The syllabus in this curriculum is outcome based rather than competency based.

Formal assessment of progress will be made at the end of each placement and at the end of F1 and F2. The clinical and/or educational supervisor's end of placement assessments will be based on multiple sources of evidence including feedback from senior doctors who have observed practice in the workplace (Placement Supervision Group). Other important evidence will be provided through the e-portfolio including team assessments of behaviour (TAB), engagement with SLEs, reflective practice throughout the placement and satisfactory demonstration of the core procedural skills required by the GMC.

Foundation doctors are expected to demonstrate that the learning outcomes, listed in *The Trainee Doctor* and mirrored in the Curriculum, have been achieved. Individuals develop at different rates and many foundation doctors are expected to achieve well beyond the minimum level specified in the Curriculum.

# Executive summary

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The vast majority of foundation doctors will have no difficulty in achieving these outcomes. When problems are identified, the foundation doctor will be encouraged to work to find solutions with the support of their clinical and educational supervisors.

At the end of F1, performance and development throughout the year will be reviewed and (if satisfactory) will lead to recommendation to the GMC that the foundation doctor satisfies the requirements for full registration and progression into F2.

At the end of F2, evidence of working towards increasingly independent practice will be reviewed and (if satisfactory) lead to the award of the Foundation Achievement of Competence Document (FACD).

## The foundation learning e-portfolio (e-portfolio)

The e-portfolio is a record of a foundation doctor's progress and development through the foundation years. Successful completion of the Curriculum requires the achievement of competence in a variety of domains based on *Good Medical Practice*. Evidence of achievement of outcomes and increasingly sophisticated performance will be recorded in the e-portfolio.

The completed e-portfolio will contribute to the end of year report. Elements of the e-portfolio may also be used in specialty interviews by the foundation doctor to demonstrate competence and highlight achievements. This means that the e-portfolio may be used to help the foundation doctor gain further employment.

This edition of the Curriculum updates the curriculum document originally published in 2005 and subsequent revisions in 2007 and 2010. It identifies the importance of supervised, practice-based learning. It is intended to be used with the e-portfolio and the Reference Guide produced by the national coordinating body for curriculum delivery, the UKFPO.



Dr David Kessel  
Chair of the Academy Foundation Programme Committee



# Purpose of the Foundation Programme

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The Foundation Programme is part of the continuum of medical education. It is the only point in medical training which is common to all United Kingdom medical students and doctors and ensures that newly qualified doctors develop their clinical and professional skills in the workplace in readiness for core, specialty or general practice training.

The Foundation Programme aims to ensure that all doctors deliver safe and effective patient care and aspire to excellence in their professional development in accordance with the GMC guidance laid down in *Tomorrow's Doctors* (2009), *The Trainee Doctor* (2011) and *Good Medical Practice* (2006).

During the programme, foundation doctors work in a supportive environment where they are properly managed and supervised, enabling them to learn through service delivery whilst ensuring that patients are not put at risk. Foundation doctors practise within their own level of competence and are provided with adequate supervision and feedback to reach higher levels of competence in existing skills and to acquire new skills. The Foundation Programme builds on and develops the responsibilities of clinical professionalism. Satisfactory progress through the Foundation Programme indicates that a doctor is moving towards independent practice.

Throughout medical school and the Foundation Programme, medical students and foundation doctors should draw upon career information and guidance and reflect on their abilities, interests and opportunities as well as anticipated service needs to make informed choices about their future career. Refer to the Career Management section in the Reference Guide and to [www.medicalcareers.nhs.uk](http://www.medicalcareers.nhs.uk) and [www.nhscareers.nhs.uk](http://www.nhscareers.nhs.uk).

The Foundation Programme aims to:

- **build on undergraduate education** by instilling recently graduated doctors with the attributes of professionalism and the primacy of patient welfare, which are required for safe and effective care of patients with both acute and long-term conditions
- **provide generic training** that ensures foundation doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions, regardless of the specialty
- **provide the opportunity to develop leadership, team working and supervisory skills** in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support
- **provide each foundation doctor with a variety of workplace experience during their foundation programme** in order to best inform career choice. Whatever career path is subsequently entered, all foundation doctors must have opportunities to understand community care provision and the majority should be offered community placements.

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## Outcomes of foundation training

Foundation year 1 (F1) enables medical graduates to begin to take supervised responsibility for patient care and consolidate the skills that they have learnt at medical school. Satisfactory completion of F1 allows the relevant university (or their designated representative in a postgraduate deanery or foundation school) to recommend to the GMC that the foundation doctor is granted full registration.

# Purpose of the Foundation Programme

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Foundation year 2 (F2) doctors remain under clinical supervision (as do all doctors in training) but take on increasing responsibility for patient care. In particular they begin to make management decisions as part of their progress towards independent practice. F2 doctors further develop their core generic skills and contribute more to the education and training of the wider healthcare workforce e.g. nurses, medical students and less experienced doctors. At the end of F2 they will have begun to demonstrate clinical effectiveness, leadership and decision-making responsibilities that are essential for hospital and general practice specialty training. Satisfactory completion of F2 will lead to the award of a Foundation Achievement of Competence Document (FACD) which indicates that the foundation doctor is ready to enter a core, specialty or general practice training programme.

# How to use the Curriculum

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To make the most of the opportunities available in foundation training, both foundation doctors and trainers need to have an appreciation of how the *Foundation Programme Curriculum* (the Curriculum) works. They should work closely together so that maximum benefit comes from the learning opportunities in the foundation years.

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## Foundation doctors

The Curriculum assumes that the foundation doctor will be proactive in managing their continuing education and career development and that they will take responsibility for detailing all achievements and progress within their e-portfolio.

The first steps are to understand:

- **the key principles of foundation training:** these are explained in the [Executive Summary](#) and [Purpose of the Foundation](#) sections
- **how foundation doctors will be supported educationally:** educational and clinical supervisors are there to help foundation doctors. The [Learning and teaching](#) and [Responsibilities of trainers](#) chapters identify and explain the system of workplace based learning and other educational opportunities which should be made available to foundation doctors
- **induction, educational and clinical supervision:** at the start of the Foundation Programme there will be a local induction which introduces the programme and sets out how it is delivered and assessed by the education provider. There will be further clinical induction sessions at the start of each placement
- **what foundation doctors are expected to achieve:** the [Syllabus](#) lists competences into subsections. Each subsection is headed by outcome descriptors indicating the levels of performance that foundation doctors must achieve in foundation year 1 (F1) and how they should be developing their ability to work with increasing independence in foundation year 2 (F2). The outcomes are the standard against which their performance will be judged and are achievable without the need to demonstrate achievement of each individual competence

At the first session with the educational supervisor, the foundation doctor may wish to discuss aspects of the Curriculum, which might include:

- o how to build on strengths from undergraduate training
- o particular areas of interest to explore
- o any potential targets for development which may need to be addressed
- o how to record achievements in the e-portfolio.

The foundation doctor and educational supervisor should also agree a timeline for this undertaking and recording of achievements, and they should agree the time and dates for subsequent meetings.

- **supervised learning events (SLEs):** these are opportunities to receive feedback from consultants and other senior colleagues. They should prompt foundation doctors to reflect on what they have learnt and help them recognise both strengths and target areas for further development. To be most effective, SLEs should cover a range of situations and challenges of varying complexity. *SLEs are an excellent opportunity to demonstrate engagement with the learning process and to allow consultants to observe foundation doctors' performance in the workplace*

# How to use the Curriculum

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- **how foundation doctors' competence will be assessed in the workplace:** foundation doctors should familiarise themselves with the [Assessment](#) section in the Curriculum.

Clinical and educational supervisors must complete reports on their foundation doctors at the end of each placement. Their summative assessment will be based on multiple observations of the foundation doctor's performance and progress in the workplace by many doctors and other healthcare professionals throughout each placement. A good way to ensure that consultants on the placement are able to comment on a foundation doctor's performance is for the foundation doctor to seek out SLEs early on and also recruit in good time an appropriate number of raters for the team assessment of behaviour (TAB). F1 doctors will also need to provide evidence of their ability to perform core procedures as mandated by the GMC.

- **how to record progress in the e-portfolio:** the foundation doctor must enrol and become familiar with the e-portfolio as a record of learning (refer to the Reference Guide). It is the foundation doctor's responsibility to populate their e-portfolio with evidence of development. The best way to achieve this is to engage with the process of SLEs from the very start of foundation
- **reflective practice:** foundation doctors should reflect on and learn from both their positive and negative experiences in order to demonstrate clinical development
- **how to make sure that progress is being made and that targets are set for future development:** this is best done by undertaking regular SLEs with senior doctors. SLE comments will indicate how the foundation doctor is performing and suggest actions which will help develop skills in the workplace. SLEs should start early in each placement to give foundation doctors time to gain the most from feedback. Foundation doctors should also read the feedback and comments from Team Assessment of Behaviour and discuss any areas of concern with the educational supervisor.

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## F1 and F2 outcomes

The syllabus describes the outcomes expected of foundation doctors in F1 and in F2 and the associated competences.

At the start of the Foundation Programme foundation doctors will concentrate their learning on achieving the F1 outcomes. It is also important to consider further professional and clinical development and work towards achievement of F2 outcomes from the outset. The foundation doctor demonstrating excellence may achieve all the outcomes, and beyond, well within the two-year time frame. However, the foundation doctor will not be signed off for F2 before finishing a full year in F2 placements.

When engaged in reflection, supervised learning events, formal assessment or self-assessment, foundation doctors should continue to refer to the framework of outcome descriptors across the syllabus to check the progress that they are expected to achieve. Educational and clinical supervisors are there to help if foundation doctors experience any difficulties with this.

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## Trainers

A trainer is an appropriately trained and experienced doctor who has responsibility for the education and training of foundation doctors in the clinical environment. A trainer provides appropriate supervision and is involved in and contributes to the learning culture. They provide feedback for learning and may have specific responsibility for assessment.

# How to use the Curriculum

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Trainers should read the [Executive Summary](#) and [How to use the Curriculum](#) sections above and the definitions of the clinical and educational supervisor (Appendix B).

It is essential to recognise trainers' central roles in:

- providing educational support in the workplace
- helping the foundation doctor to understand the role of the e-portfolio
- providing judgement about the foundation doctor's progress (to inform the assessment process based on personal observations of their performance in the workplace).

[Whilst ensuring patient safety throughout, trainers' roles may involve:](#)

- undertaking and directing supervised learning events (SLEs) in the workplace and giving immediate feedback and action points for the foundation doctor's development
- teaching both in the workplace and as part of structured learning programmes and contributing to other forms of learning
- leading a culture of education and learning where every clinical encounter affords an opportunity to improve
- encouraging foundation doctors to develop skills for managing both acute and long-term conditions
- undertaking formal roles such as clinical and educational supervision.

Trainers should be supported in their role by the local education provider (LEP) and foundation school. Trainers must also receive training for all their different roles which contribute to postgraduate education. Trainers should negotiate adequate time within their job plan to carry out agreed postgraduate training roles to a high standard.

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## Glossary

A glossary of useful terms can be found here: <http://www.gmc-uk.org/education/index.asp>.

# Syllabus

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## The syllabus in practice

### Section 1 The foundation doctor as a professional and a scholar

#### 1 Professionalism

- 1.1 Behaviour in the workplace
- 1.2 Time management
- 1.3 Continuity of care
- 1.4 Team-working
- 1.5 Leadership

#### 2 Relationship and communication with patients

- 2.1 Treats the patient as the centre of care within a consultation
- 2.2 Communication with patients
- 2.3 Communication in difficult circumstances
- 2.4 Complaints
- 2.5 Consent

#### 3 Safety and clinical governance

- 3.1 Risks of fatigue, ill health and stress
- 3.2 Quality and safety improvement

#### 4 Ethical and legal issues

- 4.1 Medical ethical principles and confidentiality
- 4.2 Legal framework of medical practice
- 4.3 Comprehension of relevance of outside bodies to professional life

#### 5 Teaching and training

#### 6 Maintaining good medical practice

- 6.1 Lifelong learning
- 6.2 Evidence, guidelines, care protocols and research

### Section 2 The foundation doctor as a safe and effective practitioner

#### 7 Good clinical care

- 7.1 Makes patient safety a priority in clinical practice
- 7.2 Ensures correct patient identification
- 7.3 History and examination
- 7.4 Diagnosis and clinical decision-making
- 7.5 Undertakes regular patient review
- 7.6 Safe prescribing

# Syllabus

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- 7.7 Safe use of medical devices
- 7.8 Infection control and hygiene
- 7.9 Medical record-keeping and correspondence
- 7.10 Interface with different specialties and with other professionals
  
- 8 Recognition and management of the acutely ill patient
  - 8.1 Promptly assesses the acutely ill, collapsed or unconscious patient
  - 8.2 Responds to acutely abnormal physiology
  - 8.3 Manages patients with impaired consciousness, including seizures
  - 8.4 Manages pain
  - 8.5 Manages sepsis
  - 8.6 Manages acute mental disorder and self-harm
  
- 9 Resuscitation and end of life care
  - 9.1 Resuscitation
  - 9.2 End of life care and appropriate use of Do Not Attempt Resuscitation (DNAR) orders/advance decisions
  
- 10 Patients with long-term conditions
  - 10.1 Manages patients with long-term conditions
  - 10.2 Supporting patient decision making
  - 10.3 Nutrition
  - 10.4 Discharge planning
  - 10.5 Health promotion, patient education and public health
  
- 11 Investigations
  
- 12 Procedures

# Syllabus

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## The syllabus in practice

All doctors must make patient safety paramount and must practise with professionalism. They must learn how to empathise with patients' conditions and develop professional attributes in accordance with the GMC's *Good Medical Practice* and *The Trainee Doctor* including:

- Integrity
- Compassion
- Altruism
- Aspiration to excellence via continuous improvement
- Respect of cultural and ethnic diversity
- Regard to the principles of equity
- Ethical behaviour
- Probity
- Honesty
- Leadership.

At all times foundation doctors must promote patient safety by:

- practising within their competence
- practising in accordance with prevailing professional standards and requirements including those expected in their placement
- seeking advice from more experienced clinicians whenever appropriate in the workplace.

All doctors must ensure that they have adequate indemnity insurance for their practice.

Those involved in managing the foundation year 1 (F1) component of the programme should refer to *The Trainee Doctor* which sets out the GMC's formal requirements for outcomes for provisionally registered doctors with a licence to practise to be included in the training programmes. UK graduates new to full registration, international medical graduates or those returning to the medical register after prolonged absence from UK practice, are required to work initially within an approved practice setting in the UK for a period of 12 months (refer to the Reference Guide).

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## Learning

Foundation doctors will learn from experience. Learning is enhanced by feedback and subsequent reflection. Supervised learning events should be used to encourage this process. Foundation doctors and their trainers are expected to seek out both scheduled and unscheduled opportunities in the workplace to observe and discuss the foundation doctor's practice, clinical skills and management.

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# Syllabus

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## Outcomes

F1 doctors should emerge with professional qualities described by the GMC and described in the Curriculum. Foundation year 2 (F2) doctors should further develop these qualities and also emerge with the understanding, skills and attitudes needed to enter core, specialty or general practice training.

The Curriculum is outcome based. For clarity, the outcome descriptors for F1 and F2 doctors are presented at the start of each subsection and expanded below as competences. Throughout the Curriculum the outcomes for F2 include those for F1, to indicate that foundation doctors are building upon previous experience and practising at a more sophisticated and increasingly independent level. Foundation doctors do not have to demonstrate that they have achieved every competence but will be expected to discuss or demonstrate achievement in each of the outcomes.

Evidence of foundation doctors' learning and developmental achievements will be recorded in the e-portfolio. Further information and declaration forms for probity, professional behaviour and personal health can be found in the e-portfolio.

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## Assessment

The foundation doctor will be judged to be performing satisfactorily if their observed performance in the workplace broadly matches the outcome descriptors. Observation of practice will underpin assessment and inform decisions regarding a doctor's development and progress through the Curriculum. The named clinical supervisor's and educational supervisor's reports will draw on evidence provided by the Placement Supervision Group and team assessment of behaviour (TAB).

The following section outlines what needs to be learnt in the Foundation Programme. Throughout this section the term 'patient' or 'carer', as appropriate in the context, should be understood to mean:

- 'patient'
- 'patient and parent'
- 'guardian'
- 'carer' and/or 'supporter'
- 'advocate'.

# Professionalism

## Section 1: The foundation doctor as a professional and a scholar

### 1. Professionalism

#### 1.1 Behaviour in the workplace

F1 and F2 outcomes
<ul style="list-style-type: none"> <li>• Acts with professionalism in the workplace and in interactions with patients and colleagues</li> </ul>
<ul style="list-style-type: none"> <li>• Acts as a role model and where appropriate a leader for medical students and other junior doctors, and assists and educates other staff</li> </ul>

#### Competences

- In all interactions with both patients and colleagues takes account of factors, where relevant, pertaining to patients’ age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status (*The Trainee Doctor* (2011); *Personal beliefs and medical practice* (2008) and *0-18 years: guidance for all doctors* (2007))
- Acts with empathy, honesty and sensitivity and in a non-confrontational manner
- Respects and supports the privacy and dignity of patients
- Is courteous, polite, considerate, honest and professional with patients, relatives and colleagues
- Has a non-judgemental approach
- Is aware of patient expectations around personal presentation of doctors such as dress and social behaviour
- Acts as a responsible employee in accordance with the employer’s policies e.g.:
  - o Completion of mandatory training
  - o Responsibility for organising leave
  - o Responsibility for prompt reporting of absence.

#### 1.2 Time management

F1 outcomes
<ul style="list-style-type: none"> <li>• Is punctual and organised</li> </ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"> <li>• Delegates tasks and ensures that they are completed</li> </ul>

#### Competences

- Is punctual for all duties, including handovers, clinical commitments and teaching sessions
- Integrates supervised learning events (SLEs) and other learning responsibilities into the weekly programme of work
- Keeps a list of allocated tasks and ensures that all are completed

# Professionalism

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- Organises and prioritises workload regularly and appropriately
- Delegates or calls for help in a timely fashion when falling behind
- Demonstrates the ability to adjust decision-making in situations where staffing levels and support are reduced e.g. out of hours
- Supervises others to ensure appropriate prioritisation and delivery of care.

## 1.3 Continuity of Care

F1 outcomes
<ul style="list-style-type: none"><li>• Brings accurate information to handover and indicates priorities appropriately</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Organises handover and task allocation, anticipating problems for the next clinical team/shift and takes pre-emptive action where required</li></ul>

### Competences

- Monitors clinical evolution and treatment plan for patients under their care
- Summarises accurately and documents the main points of patients' diagnoses, active and potential problems, and management plans
- Ensures satisfactory completion of tasks at the end of the shift/day with appropriate reflection on performance
- Recognises that handover of care is central to patient safety
- Ensures safe continuing care of patients by handover to on-call staff
- Identifies potential problems and required actions and ensures that these are highlighted clearly in handover to colleagues
- At handovers accepts directions and allocation of tasks from seniors
- Makes adequate arrangements for cover e.g. handing over bleep during educational sessions.

## 1.4 Team-working

F1 outcomes
<ul style="list-style-type: none"><li>• Displays understanding of personal role within their team including supporting the team leader and listening to the views of other healthcare professionals</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Organises and allocates work within their clinical team to optimise effectiveness</li></ul>

### Competences

- Integrates and interacts appropriately with their clinical team
- Contributes to multidisciplinary team (MDT) meetings
- Encourages open and appropriately directed communication within teams
- Demonstrates clear and effective communication within the healthcare team

# Professionalism

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- Cross-checks instructions and actions with colleagues e.g. medicines to be injected
- Accepts appropriate directions and allocation of tasks
- Demonstrates awareness of work pressures on others and willingness to support other staff and help reorganise workloads as necessary.

## 1.5 Leadership

F1 outcomes
<ul style="list-style-type: none"><li>• Demonstrates a leadership role within the team in certain clinical situations, e.g. when supporting medical students during student assistantships</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Demonstrates extended leadership role within the team by making decisions and dealing with complex situations across a greater range of clinical and non-clinical situations, e.g. supervising F1 doctors, leading resuscitation, directing ward rounds, organising handover, etc</li></ul>

### Competences

- Shows leadership skills where appropriate and at the same time works effectively with others towards a common goal
- Understands:
  - o organisational structures
  - o chains of responsibility including principles of line management in medical and non-medical staff
  - o the importance of leadership (*Medical Leadership Competency Framework (2009)* and *Guidance for Undergraduate Medical Education - Integrating the Medical Leadership Competency Framework (2010)*).

# Relationship and communication with patients

## 2. Relationship and communication with patients

### 2.1 Treats the patient as the centre of care within a consultation

F1 outcomes
<ul style="list-style-type: none"><li>• Prioritises the needs of patients above personal convenience without compromising personal safety or safety of others</li><li>• Works in partnership with patients in an open and transparent manner, treats patients as individuals and respects their perspective/views on their own treatment</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Works with patients and colleagues to develop sustainable individual care plans to manage patients' acute and long-term conditions</li></ul>

#### Competences

- Considers the patient as a whole, respecting their individual needs, dignity and right to privacy, autonomy and confidentiality
- Discusses management options with patients
- Recognises patients' expertise about their care
- Respects patients' views and encourages patients with knowledge of their condition to make appropriately informed decisions about their care
- Demonstrates understanding to the whole clinical team that respect of patients views and wishes is central to the provision of high quality care
- Considers care pathways and the process of care from patients' perspectives
- Respects patients' right to refuse treatment or take part in research
- Recognises and responds to patients' ideas, concerns and expectations
- Deals appropriately with angry or dissatisfied patients.

### 2.2 Communication with patients

F1 outcomes
<ul style="list-style-type: none"><li>• Communicates effectively and with understanding and empathy in straightforward consultations</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Demonstrates increasing ability and effectiveness in communicating more complicated information in increasingly challenging circumstances e.g. time limited consultations (outpatients and GP clinics) and as outlined (2.3 - 2.5)</li><li>• Deals increasingly independently with queries from patients and relatives</li></ul>

#### Competences

- Ensures sufficient time and appropriate environment for communication
- Listens actively and enables patients to express concerns and preferences, ask questions and make personal choices
- Recognises that patients may have unspoken concerns and communicates in an empathic manner to elicit and address these

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# Relationship and communication with patients

- Responds to patients’ queries or concerns
- Seeks advice promptly when unable to answer patients’ queries or concerns
- Explains options clearly and checks patients’ understanding
- Provides or recommends relevant written/on-line information appropriate for individual patient’s needs
- Documents communications with patients in their records
- Teaches communication skills to students and colleagues.

### 2.3 Communication in difficult circumstances

F1 outcomes
<ul style="list-style-type: none"> <li>• Breaks bad news to patients or carer/relative effectively and compassionately, and provides support, where appropriate</li> </ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"> <li>• Recognises where patient’s capacity is impaired and takes appropriate action</li> </ul>

Competences

- Demonstrates involvement with others in the team when breaking bad news
- Considers any acute or chronic mental or physical condition that may have an impact on communication understanding
- Considers patients’ personal factors including relevant home and work circumstances
- Ensures sufficient time and a suitable environment for discussions
- Deals appropriately with distressed patients/carers and seeks assistance as appropriate
- Demonstrates the ability to communicate when English is not a patient’s first language, including the appropriate use of an interpreter
- Manages three-way consultations e.g. with an interpreter or with a child patient and their family/carers
- Understands how the communication might vary when the patient or carer has learning or communication difficulties themselves e.g. deafness
- Deals appropriately with angry or dissatisfied patients, trying to calm the situation and seeking assistance as appropriate.

### 2.4 Complaints

F1 and F2 outcomes
<ul style="list-style-type: none"> <li>• Recognises situations which might lead to complaint or dissatisfaction</li> <li>• Apologises for errors and takes steps to prevent/minimise impact</li> </ul>

Competences

- If involved in a complaint, deals with it under guidance including:
  - o Ensuring appropriate arrangements for patient care
  - o Communicating with other staff and patients where appropriate

# Relationship and communication with patients

- o Demonstrating appropriate learning from episode
- o Obtaining appropriate mentoring advice and counselling
- Identifies or describes a potential complaint and the role of the multidisciplinary team in methods of resolution
- Understands and addresses common reactions of patients, family and clinical staff when a treatment has been unsuccessful or when there has been a clinical error
- Seeks to remedy patients' or relatives' concerns with help from senior colleagues and/or other members of the multidisciplinary team
- Understands that complaints do not necessarily imply blame and is open to discussion of the issues concerned
- Demonstrates understanding of the local complaints process and its value in learning for both the individual and the organisation
- Consults with other members of the team on factual information/explanations of error to ensure that the patient is given a single clear picture of causation of fault rather than suggestions or probabilities
- Follows an untoward incident or complaint through the trust/LEP process.

## 2.5 Consent

F1 outcomes
<ul style="list-style-type: none"> <li>• Obtains consent as appropriate in accordance with <i>Consent: patients and doctors making decisions together (2008)</i> including for core procedures</li> </ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"> <li>• Increases the breadth of procedures for which consent is taken in accordance with GMC guidance</li> </ul>

### Competences

- Practises in accordance with *Consent: patients and doctors making decisions together (GMC, 2008)* and does not take consent when contrary to GMC guidance
- Describes the principles of valid consent and obtains valid consent after appropriate training
- Gives each patient the information they 'want' or 'need' in a way they can understand in order to obtain valid consent
- Provides or recommends relevant written/on-line information appropriate for patients' needs
- Listens to patient concerns and answers their questions regarding treatment
- Considers any acute or chronic mental or physical condition that may have an impact on the consent process both in terms of understanding and influence on outcomes of the procedure
- Understands how to undertake a capacity assessment and does so where appropriate
- In patients who lack capacity understands and applies the principle of 'best interests'
- Ensures that the patient with capacity understands and retains information long enough to make a decision
- Considers any acute or chronic mental or physical condition that may have an impact on the consent process both in terms of understanding and influence on outcomes of the procedure.

# Safety and clinical governance

## 3. Safety and clinical governance

### 3.1 Risks of fatigue, ill health and stress

F1 outcomes
<ul style="list-style-type: none"><li>Recognises that fatigue and health problems in healthcare workers (including self) can compromise patient care and where appropriate, must be urgently addressed</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>If applicable recognises fatigue/stress/illness in members of the clinical team and seeks senior guidance to reduce this</li></ul>

#### Competences

- Recognises:
  - that health problems (personal or of others) must not compromise patient care or expose colleagues or patients to harm
  - the effects of stress/fatigue on performance (personal or of others) and can demonstrate how to access help should it be required
  - the need to identify and minimise the impact of fatigue on themselves and their performance
  - the need for immunisations and ensures own are up to date in accordance with local policy
  - that medicines can reduce personal or a colleague's performance and ensures that occupational health advice is sought as necessary
  - the need to report personal health problems in a timely manner
  - the risks to patients if personal performance is compromised by health problems
  - the risks to patients from transmission of blood-borne infection
  - the availability of support facilities
  - the circumstances when self-referral to occupational health services is appropriate and adheres to local sickness and return to work policies.



# Safety and clinical governance

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## 3.2 Quality and safety improvement

F1 outcomes
<ul style="list-style-type: none"><li>• Delivers high quality care in accordance with local/national guidelines</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Manages, analyses and presents at least one quality improvement project and uses the results to improve patient care</li></ul>

### Competences

#### General

- Understands that clinical governance is the over-arching framework that unites a range of quality improvement activities to safeguard standards and facilitate improvements in clinical services
- Understands the principles of quality and safety improvement in healthcare
- Reflects on care plans used to improve patient safety
- Discusses safety issues in the framework of case based discussions
- Demonstrates awareness of local major incident planning and their potential role in any such incident
- Critically analyses clinical guidelines and care bundles
- Recognises the benefits and limitations of guidelines and care pathways.

#### Quality Improvement

- Understands and takes part in systems of quality assurance and clinical improvement in clinical work and training
- Performs a quality improvement project and is able to understand the quality improvement process
- Contributes to discussions on improving clinical practice
- Describes opportunities for improving the reliability of care following audit, adverse events or 'near misses'
- Describes root-cause analysis
- Demonstrates understanding of the importance of reporting, discussing, and learning from all incidents and concerns related to patient safety
- Contributes to discussions on improving clinical practice.

#### Audit Cycle

- Describes the audit cycle and recognises how it relates to the improvement of clinical care
- Participates in a trust or directorate audit/clinical governance meeting
- Makes audit links explicitly to learning/professional development portfolios
- Recognises the features of an effective audit that makes real changes in practice
- Reflects on an audit or Health Improvement Project related to a patient safety issue.

# Ethical and legal issues

## 4. Ethical and legal issues

### 4.1 Medical ethical principles and confidentiality

F1 and F2 outcomes
<ul style="list-style-type: none"><li>Practises in accordance with the principles of <i>Good Medical Practice</i> (2013), <i>The Trainee Doctor</i> (2011) and <i>Confidentiality</i> (2009)</li></ul>

#### Competences

- Describes and applies the principles of confidentiality (*Confidentiality*, (GMC, 2009)
- Maintains confidentiality and only shares clinical information, spoken or written, with appropriate individuals or groups where clinically relevant
- Complies with information governance standards of confidentiality and data protection
- Describes and demonstrates an understanding of the main principles of medical ethics, including autonomy, justice, beneficence, non-maleficence and confidentiality as they apply to medical practice, refer to *Reporting criminal and regulatory proceedings within and outside the UK* (GMC, 2008)
- Ensures privacy when discussing sensitive issues
- Uses and shares clinical information appropriately while respecting confidentiality
- Provides care and treatment in accordance with the principles of patients' best interests, autonomy and rights
- Completes the Statement for Fitness to work appropriately.

### 4.2 Legal framework of medical practice

F1 and F2 outcomes
<ul style="list-style-type: none"><li>Takes personal responsibility for and is able to justify decisions and actions</li></ul>

#### Competences

- Demonstrates the knowledge and skills to cope with ethical and legal issues that occur during the management of patients with medical problems or mental illness
- Advises patients/acts on the legal implications of illness e.g. where this may affect ability to drive (Driver and Vehicle Licensing Agency '*For Medical Practitioners At A Glance Guide to the Current Medical Standards of Fitness to Drive*') or employment
- Recognises the need for restraint of some patients with mental illness according to the appropriate legal framework
- Initiates restraining orders against some patients with mental illness according to the appropriate legal framework
- Discusses the risks of legal and disciplinary action if a doctor fails to achieve the necessary standards of practice and care
- Describes and applies the principles of child protection procedures
- Completes death certificates and liaises with the coroner/procurator fiscal
- Completes cremation forms appropriately
- Minimises risk of exposing a pregnant woman to radiation
- Discusses the implications of a living will or advance decision to refuse treatment.

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# Ethical and legal issues

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## 4.3 Comprehension of relevance of outside bodies to professional life

F1 and F2 outcomes
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- |  |
|--|
| <ul style="list-style-type: none"><li>• Recognises many organisations and bodies that are involved in medical education and regulation of medical practice</li></ul> |
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### Competences

- Understands that many local, national and international organisations and bodies (such as those listed below) are involved in NHS structure, the safe practice of medicine, the delivery of medical education and regulation of medical practice:
  - o General Medical Council (GMC)
  - o Royal Colleges and Faculties
  - o UK Foundation Programme Office (UKFPO)
  - o Postgraduate deaneries
  - o Foundation and postgraduate specialty schools
  - o Defence organisations
  - o British Medical Association (BMA)
  - o Medicines and Healthcare products Regulatory Agency (MHRA)
  - o National Institute for Health and Clinical Excellence (NICE)
  - o European Medicines Agency (EMA)
  - o Local authorities
  - o Voluntary organisations.

# Teaching and training

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## 5. Teaching and training

F1 and F2 outcomes
<ul style="list-style-type: none"><li>• Delivers presentations and teaching sessions which support learning</li><li>• Participates in the assessment of medical students and other healthcare professionals and provides constructive feedback</li><li>• Reflects on feedback from learners and supervisors to improve own teaching and training skills</li></ul>

### Competences

- Recognises that doctors have a role as teachers as described in *Good Medical Practice*
- Teaches, supports and gives feedback to medical students and other members of the multidisciplinary team (MDT) where appropriate
- Understands the role and value of supervised learning events including 'developing the clinical teacher'
- Demonstrates appropriate preparation for teaching/presentations at meetings
- Acts as a role model for other doctors and healthcare workers
- Contributes to the appraisal, assessment or review of students and other colleagues
- Draws on teaching and learning skills when working in partnership with patients
- Encourages an open, blame free working environment where it is easy for students and F1 doctors to be honest about mistakes and errors and understand how important it is to learn from these.

# Maintaining good medical practice

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## 6. Maintaining good medical practice

### 6.1 Lifelong learning

F1 outcome
<ul style="list-style-type: none"><li>• Maintains personal development e-portfolio by recording learning needs and personal reflection including career development and planning</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Recognises personal learning needs, addresses these proactively and sets SMART* goals</li></ul> <p><i>*Specific, Measurable, Achievable, Realistic, Time limited</i></p>

#### Competences

- Recognises that foundation doctors need to demonstrate acquisition of the knowledge, attitudes, behaviours and skills to start self-directed lifelong learning
- Recognises that all doctors continue to refine their practice throughout their careers to enhance personal contribution to the quality of patient care
- Reviews professional learning needs and reflects on the best conditions for personal learning.
- Takes steps to address these needs, seeking out role models and learning from the behaviours of the best clinical practitioners and leaders
- Demonstrates engagement in lifelong learning by seeking feedback from experienced trainers on aspects of clinical practice through supervised learning events (SLEs)
- Recognises errors and mistakes and demonstrates measures to learn from them by discussion and reflection
- Implements changes in practice to improve performance as a result of reflecting on personal experience, multi-source feedback (MSF) and feedback from SLEs. Refer to Taking up and ending appointments (2008)
- Arranges and prepares for own appraisal in a timely manner
- Provides evidence to demonstrate continuing personal and professional development via e-portfolio and supporting documentation.

# Maintaining good medical practice

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## 6.2 Evidence, guidelines, care protocols and research

F1 outcome
<ul style="list-style-type: none"><li>• Recognises, understands and follows appropriate guidelines</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Finds and interprets evidence relating to clinical questions</li><li>• Demonstrates the use of literature, guidelines and experience in the development of clinical skills over the previous year</li></ul>

### Competences

- Supports patients in interpreting evidence including understanding the evidence in the context of any underlying long-term condition the patient may have
- Appraises recent research, and discusses findings with colleagues to advocate specific action
- Recognises the limitations of guidelines and care pathways in certain circumstances.

# Good clinical care

## Section 2: The foundation doctor as a safe and effective practitioner

### 7. Good clinical care

#### 7.1 Makes patient safety a priority in clinical practice

F1 outcome
<ul style="list-style-type: none"><li>• Delivers high-quality reliable care in accordance with clinical care pathways, care bundles, protocols and consultant prescription</li><li>• Recognises and works within limits of competency requesting appropriate assistance/ senior guidance to ensure patient safety</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Recognises when patient safety is at risk and institutes changes to reduce risk</li></ul>

#### Competences

- Always recognises own level of competence and asks for help from appropriate sources in an appropriate and timely fashion
- Only delegates to colleagues with appropriate qualifications and experience
- Recognises the potentially vulnerable patient e.g. children, older people, those with learning difficulties, potential victims of abuse and those in need of extra support
- Understands limitations of clinical pathways in certain individual patient circumstances
- Describes ways of identifying poor performance in self and colleagues, including senior colleagues, and the appropriate lines of communication for these issues
- Draws attention to potential risks to patients regardless of status of colleagues
- Supports colleagues who have problems with their performance, conduct or health
- Demonstrates a knowledge of how and when to report critical incidents, adverse events and 'near misses' to local/national reporting systems
- Demonstrates knowledge of risk reduction strategies and of how to undertake a significant event analysis
- Contributes to protocol reviews and updates if asked.

#### 7.2 Ensures correct patient identification

F1 and F2 Outcomes
<ul style="list-style-type: none"><li>• Ensures patient safety by positive identification of the patient at each encounter</li><li>• Ensures correct patient identification before obtaining consent for surgery / procedures</li></ul>

#### Competences

- Ensures correct patient identification using appropriate 2 or 3 point checks (e.g.name, date of birth, hospital number, address) in accordance with local protocols and national guidance
- Crosschecks identification before administration of blood products / IV drugs

# Good clinical care

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- Recognises that incorrect patient identification / specimen labelling are preventable sources of error
- Utilise additional identification safety checks such as hospital and NHS number e.g. when acquiring consent / performing procedures / labelling specimens / administering drugs or blood products / requesting investigations
- Recognises the importance of following safety checks such as WHO safer surgery checklist or local equivalent
- Recognises the risks to patients of incorrect identification e.g. wrong patient, wrong site surgery, incorrect treatment, incorrect test, blood transfusion reaction.

## 7.3 History and examination

F1 outcomes
<ul style="list-style-type: none"><li>• Obtains accurate patient history and examination utilising all relevant sources of information</li><li>• Performs accurate physical examination and elicits physical signs</li><li>• Presents patient history and findings succinctly and accurately</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Rapidly makes a focused clinical assessment in different settings and with uncooperative patients</li></ul>

### Competences

- Takes a focused family history, and constructs and interprets a family tree, where relevant
- Takes an occupational history, where relevant
- Obtains collateral history, when available
- Routinely scrutinises existing patient records and other sources of evidence/information
- Asks for a chaperone, where appropriate
- Demonstrates accomplished and targeted examination skills and appropriate use of equipment, including an ophthalmoscope
- Explains and gains appropriate consent for the examination procedure
- Performs a mental state assessment
- Demonstrates awareness of safeguarding children (Levels 1 and 2) and vulnerable adults
- Demonstrates the ability to identify, refer and participate in both the medical assessment and care planning in cases where the interests of a child, vulnerable adult, including those with learning difficulties or a potential victim of abuse, need safeguarding
- Demonstrates an awareness of the potential for physical, psychological and sexual abuse of patients, and manages such cases in a similar way to safeguarding children and vulnerable adults.



# Good clinical care

## 7.4 Diagnosis and clinical decision making

F1 outcomes
<ul style="list-style-type: none"><li>• Makes appropriate differential diagnosis and formulates a management plan</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Reviews initial diagnosis (with F1), refines problem lists and plans appropriate strategies for investigation and management</li></ul>

### Competences

- Works towards an appropriate differential diagnosis and establishes a problem list
- Takes account of probabilities in ranking differential diagnoses
- Constructs a management plan and communicates requests/instructions to other healthcare professionals
- Makes a judgement about prioritising actions on the basis of the differential diagnosis and clinical setting
- Initiates appropriate venous thromboembolic (VTE) prophylaxis according to local protocols
- Requests screening for any disorder which could put other patients or staff at risk by cross contamination e.g. Methicillin-Resistant Staphylococcus Aureus (MRSA)
- Reviews, and where appropriate, adjusts differential diagnosis in the light of developing symptoms and response to therapeutic interventions.

## 7.5 Undertakes regular patient review

F1 outcomes
<ul style="list-style-type: none"><li>• Takes responsibility for regular reviews and expedites patient investigation and management</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Refines appropriate strategies for investigation and management and leads regular reviews of treatment response to oversee patients' progress along treatment plan</li></ul>

### Competences

- Prioritises problems
- Pursues further history and examination in the light of the differential diagnosis
- Considers mental illness or disturbance as being a factor in patients' presentation, as well as the impact of physical illness in patients' mental health
- Recognises that the acute illness may be an acute exacerbation of a long-term disease
- Undertakes focused further history-taking in difficult circumstances and/or when the patient is unable to co-operate
- Recognises the impact of co-morbidity and poly-pharmacy on the presentation of acute illness
- Monitors, anticipates and plans for future stages of care
- Documents review in clinical records.

# Good clinical care

## 7.6 Safe prescribing

F1 outcomes
<ul style="list-style-type: none"><li>• Ensures correct patient identification when prescribing</li><li>• Prescribes medicines, blood products and fluids accurately and unambiguously and regularly reviews drug chart</li><li>• Prescribes appropriately for common important presentations e.g. exacerbation of chronic obstructive pulmonary disease, congestive cardiac failure, pain</li><li>• Recognises and adheres to local restrictions to prescribing e.g. relating to chemotherapy and immunosuppressant agents</li><li>• Recognises that F1 doctors should only repeat prescribe immunosuppressant agents (apart from corticosteroids) after completing specific training</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Anticipates changes in medication required on admission, during stay, at discharge and in outpatients</li><li>• Use strategies other than prescribing to manage patients' symptoms</li><li>• Only prescribes or administers chemotherapy or immunosuppressants after completing specific training</li></ul>

### Competences

- Takes an accurate drug history, including self-medication, use of herbal products and enquiry about allergic and other adverse reactions
- Discusses drug treatment and administration, including unwanted effects and interactions, with patients and, when appropriate, carers, using aids such as patient information leaflets
- Prescribes drugs and treatments appropriately, clearly and unambiguously in accordance with *Good Practice in prescribing medicines* (GMC, 2008) (for an F1 in hospital and for F2 for community, including on FP10)
- Understands and applies the principles of safe prescribing for different patient groups including children, women of child-bearing potential, pregnant women
- Considers the effect of hepato-renal dysfunction on pharmacokinetics
- Recognises the potential hazards related to different routes of drug administration (e.g. oral, intramuscular, intravenous, intrathecal)
- Understands that specific training is required prior to prescribing or administering cytotoxic chemotherapy and/or immunosuppressant drugs (apart from corticosteroids)
- Uses the *British National Formulary* (BNF) (and *BNF for Children* where appropriate), plus pharmacy and computer-based prescribing-decision support to access information about drug treatments, including drug interactions
- Performs dosage calculations accurately and verifies that the dose calculated is of the right order
- Works closely with pharmacists and more experienced prescribers to ensure accurate, safe and effective error-free prescribing, whilst recognising that the legal responsibility remains with the prescriber
- Transfers previous prescriptions accurately and appropriately when patients move between different areas

# Good clinical care

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- Chooses appropriate intravenous fluids as vehicles for intravenous drugs and calculates the correct volume and flow rate
- Monitors therapeutic effects and adjusts treatments and dosages appropriately
- Recognises and initiates action for common adverse effects of drugs and communicates these to patients, including potential effects on work and driving
- Prescribes oxygen appropriately including to patients with the risk of carbon dioxide retention
- Prescribes controlled drugs within appropriate legal framework in hospital and understands the management and prescribing of controlled drugs in the community
- Understands the importance of security issues in respect of prescriptions
- Notifies regulatory agencies of reportable adverse drug reactions to medicines and blood products
- Demonstrates awareness of, and follows, guidelines/protocols on safe cross matching and the use of blood and blood products
- Prescribes blood/blood products appropriately
- Administers blood products safely and recognises transfusion reactions
- Recognises the importance of religious/cultural beliefs relating to blood products
- Seeks evidence about appropriateness and effectiveness of therapies in making prescribing decisions, including evidence which may be available in National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN) and local guidelines
- Understands the importance of summaries of product characteristics and implications of off-label and unlicensed use of medicinal products
- Understands and is aware of critical medication which needs to be administered urgently as per National Patient Safety Agency (NPSA) guidelines
- Relates prescribing activity to available prescribing guidelines/audit data e.g. antibiotic usage
- Follows the guidance in *Good Medical Practice* in relation to self-prescribing and prescribing for friends and family
- Completes local prescribing learning as required
- Anticipates, prevents and manages adverse drug and transfusion reactions, and understands how and when to report suspected adverse reactions to the Medicines and Healthcare product Regulatory Agency (MHRA)
- Deals with complex situations including drug contra-indications
- Is able to work productively with hospital and community pharmacists in managing medicines
- Seeks appropriate advice with prescribing including medication for discharge.

## 7.7 Safe use of medical devices

F1 and F2 outcomes
<ul style="list-style-type: none"><li>• Demonstrates correct use of relevant medical devices and interpretation of non-invasive monitoring</li></ul>

### Competences

- Demonstrates an ability when necessary to set up and use appropriate medical devices safely e.g. for monitoring blood pressure, pulse and oxygen saturation, external defibrillator, electrocardiogram, glucometer, infusion of fluids etc. (NB this excludes implantable devices)

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# Good clinical care

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- Understands and shows a familiarity with IT systems including local computing systems e.g. results servers, PACS and image review systems, electronic request/order systems, electronic patient record systems
- Knows where relevant equipment is located
- Understands the importance of reporting device related adverse incidents to the MHRA.

## 7.8 Infection control and hygiene

F1 and F2 outcomes
<ul style="list-style-type: none"><li>• Demonstrates continuously high standard of practice in infection control techniques</li><li>• Complies with local requirements for learning related to infection control</li><li>• Complies with local requirements for immunisation against communicable disease</li></ul>

### Competences

#### Personal

- Demonstrates correct techniques for hand hygiene with hand gel and with soap and water
- Consistently uses hand hygiene between patient contacts in clinical settings
- Challenges others who are not observing best practice in infection control
- Uses personal protective equipment (gloves, masks, eye protection etc.) appropriately
- Follows aseptic technique
- Adheres to policy regarding the disposal of sharps and clinical waste
- Involves the infection control team at an appropriate early stage
- Takes appropriate microbiological specimens in a timely fashion
- Is alert to sequences of bacteriological findings from different patients suggesting cross infection
- Follows local guidelines/protocols for antibiotic prescribing.

#### Organisational

- Demonstrates the knowledge, skills, attitudes and behaviours to reduce the risk of cross-infection and healthcare-associated infections
- Describes the negative impact of hospital acquired infection on a disease course e.g. delayed discharge, increased morbidity and mortality
- Understands the particular risks of infectious diseases for those with chronic disease who are in institutional care
- Describes the concept of outbreak management within healthcare settings e.g. diarrhoea on a ward
- Informs the competent authority of notifiable diseases.

# Good clinical care

## 7.9 Medical record-keeping and correspondence

F1 outcomes
<ul style="list-style-type: none"><li>• Maintains accurate, contemporaneous notes</li><li>• Seeks out and records results of investigations and tests in a timely manner</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Formulates accurate and succinct clinic letters and discharge summaries</li></ul>

### Competences

- Routinely and regularly records information in compliance with the *Clinician's Guide to Record Standards* (AoMRC, 2008) including:
  - o comprehensive, accurate, logical medical records and pertinent accounts of history, examination, investigations, management decisions and progress
  - o information given to patients/relatives/carers, details of discussion with patients, and patients' views on investigative and therapeutic options, in accordance with *Consent: patients and doctors making decisions together* (2008)
  - o a summary of professional telephone communications and telephone consultations with patients/carers
  - o ensures all records are timed, dated and clearly attributable including GMC number
- Demonstrates record keeping and intra/internet access skills to other doctors/students
- Describes the medico-legal importance of good record keeping
- Uses information systems and processes in supporting the effective management of clinical care pathways
- Structures letters clearly to communicate the details of long-term conditions and the findings and outcomes of acute episodes so that they can be read and understood by other professionals and patients
- Ensures that letters and discharge summaries are written and sent out in a timely and efficient manner.

## 7.10 Interface with different specialties and with other professionals

F1 outcomes
<ul style="list-style-type: none"><li>• Makes appropriate referrals within the hospital</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Takes part in the process of referral from primary to secondary and/or tertiary care and vice versa</li><li>• Able to make referrals across boundaries and through networks of care</li></ul>

# Good clinical care

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## Competences

- Understands:
  - o the importance of the entire healthcare team
  - o the importance of effective communication with colleagues in other disciplines
  - o shared care arrangements
  - o the challenges of providing care within a variety of clinical settings and potential difficulties of navigating boundaries between different professionals and specialties
  - o the strengths and weaknesses of guided care pathways and networks of care
  - o how to make a referral across care boundaries
  - o guided care pathways between teams and primary and secondary care
  - o how to maintain appropriate patient confidentiality across care boundaries
  - o how/when to communicate effectively and confidentially with non NHS organisations, e.g. the Citizens Advice Bureau
  - o the role and process of inter specialty and inter organisational referrals
- Able to:
  - o make a referral to another medical team/across care boundaries
  - o liaise effectively and confidentially with other professionals from other NHS teams and from non NHS organisations e.g. social workers, probation officers.

# Recognition and management of the acutely ill patient

## 8. Recognition and management of the acutely ill patient

### 8.1 Promptly assesses the acutely ill, collapsed or unconscious patient

Competences are context-dependent and so will not necessarily be at the same level in all acute situations. For example, foundation doctors will not be expected to have the same level of competence to manage seriously ill children as that expected with adults. All foundation doctors should always work within their own level of competence and seek senior assistance and support when appropriate in a timely manner.

F1 outcomes
<ul style="list-style-type: none"><li>• Uses an Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach to assessing acutely unwell or collapsed patients</li><li>• Recognises patients with acute illness requiring urgent/emergency treatment and initiates early management</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Rapidly performs primary assessment, evaluates and recognises the severity of illness in acutely ill or collapsed patients</li><li>• Recognises the different prognostic significance of the component elements of Glasgow Coma Scale (GCS) and takes appropriate action</li></ul>

#### Competences

- Uses Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach to assessing the acutely unwell or collapsed patients
- Uses the GCS or Alert, Voice, Pain, Unresponsive (AVPU) to quantify conscious level
- Investigates and analyses abnormal physiological results in the context of the clinical scenario to elicit and treat cause
- Describes where to find normal age-related reference ranges for vital signs in infants and children where appropriate
- Recognises the importance of recording and noting changes in physiological score
- Recognises the prognostic significance of elements of physiological scores
- Uses monitoring (including blood glucose) to inform the clinical assessment
- Recognises importance and implications of clinical early warning scores
- Asks patients and staff appropriate questions to prioritise care
- Prioritises tasks according to clinical urgency and reviews patients in a timely manner
- Seeks senior help with the further management of acutely unwell patients both promptly and appropriately
- Summarises and communicates findings to colleagues succinctly
- Appropriately communicates with relatives/friends and offers support.

# Recognition and management of the acutely ill patient

## 8.2 Responds to acutely abnormal physiology

F1 outcomes
<ul style="list-style-type: none"> <li>• Takes appropriate timely action to treat a patient with abnormal physiology</li> </ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"> <li>• Anticipates and plans appropriate action to prevent deterioration in vital signs</li> </ul>

### Competences

- Formulates treatment plan in response to acutely abnormal physiology taking into account other co-morbidities and long-term conditions
- Administers and prescribes oxygen, fluids and antimicrobials as appropriate (see *Good Clinical Care: Safe Prescribing and Infection Control*)
- Identifies electrolyte imbalance and chooses a safe and effective method of correction
- Recognises when arterial blood gas sampling is indicated, identifies abnormal results, interprets results correctly and seeks senior advice
- Delivers a fluid challenge safely to an acutely ill patient, where appropriate
- Plans appropriate action to try to prevent deterioration in vital signs
- Reassesses ill patients appropriately after starting treatment
- Monitors efficacy of interventions
- Recognises the indicators for intensive care unit review when physiology abnormal.

## 8.3 Manages patients with impaired consciousness, including seizures

F1 outcomes
<ul style="list-style-type: none"> <li>• Investigates causes of impaired/deteriorating consciousness and seizures and commences treatment to correct them</li> </ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"> <li>• Manages / treats the unconscious or convulsing patient</li> <li>• Understands the impact on the activities of daily living of convulsions and communicates these to patients and their carers/relatives</li> </ul>

### Competences

- Assesses conscious level (GCS or AVPU)
- Seeks corroborative history from witnesses in the case of episodes of impaired consciousness
- Treats ongoing seizures
- Recognises causes of impaired consciousness and seizures and seeks to correct them
- Recognises the potential for airway and respiratory compromise in the unconscious patient (including indications for intubation)
- Understands the importance of supportive management in impaired consciousness
- Seeks senior help for patients with impaired consciousness in an appropriate and timely way
- Recognises the need to refer to a regional neurological/neurosurgical centre for appropriate patients.



# Recognition and management of the acutely ill patient

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## 8.4 Manages pain

F1 outcomes
<ul style="list-style-type: none"><li>• Safely prescribes and administers common analgesic drugs including patient controlled analgesia</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Anticipates and prevents pain whenever possible</li><li>• Ensures safe prescribing tailoring to changing requirements throughout patients' care journey</li></ul>

### Competences

- Recognises importance of pain control
- Evaluates the cause and severity of pain (ideally using a verified pain score)
- Manages pain safely and effectively
- Prescribes analgesic drugs in a safe and timely manner
- Understands the common side effects of analgesic drugs and takes steps to minimise or prevent them
- Assesses the efficacy of analgesic interventions
- Communicates changes to analgesic prescriptions with other health carers in the community and hospital including acute pain and palliative care teams.

## 8.5 Manages sepsis

F1 outcomes
<ul style="list-style-type: none"><li>• Identifies and manages sepsis early in accordance with local protocols</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Identifies and treats the focus of infection in accordance with sepsis resuscitation bundle e.g. <a href="http://www.survivingsepsis.org">http://www.survivingsepsis.org</a></li></ul>

### Competences

- Understands the seriousness of sepsis
- Understands and applies the principles of managing a patient with sepsis
- Involves the infection control team at an appropriate early stage
- Takes appropriate microbiological specimens in a timely fashion
- Follows local guidelines/protocols for antibiotic prescribing.

# Recognition and management of the acutely ill patient

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## 8.6 Manages acute mental disorder and self-harm

F1 outcomes
<ul style="list-style-type: none"><li>Assesses and manages patients' mental health including the risk of harm to self and others</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>Describes when and how to apply the relevant mental health and capacity legislation</li></ul>

### Competences

- Describes and recognises common presenting features of acute mental disorder including disturbance of behaviour, mood, thought/cognition, and perception
- Performs a mental state examination
- Recognises potential risks to patient and health care professionals
- Takes appropriate steps to protect the patient, dependants, self and colleagues from harm
- Considers underlying causes of severe mental disturbance including acute confusional states, psychosis and substance use/withdrawal, early signs of dementia
- Ensures appropriate screening for metabolic, medical and drug induced changes in mental state
- Understands and applies the principles of managing a patient with acute mental disorder and self-harm
- Understands the spectrum of therapeutic interventions for the management of the acutely disturbed patient, including restraint
- Recognises the need to seek help from appropriate health care professionals
- Understands the importance of liaising with community care and specialist teams to ensure seamless care between acute and long-term care providers
- Understands *Accountability in multi-disciplinary and multi-agency mental health teams* (2005).

# Resuscitation and end of life care

## 9. Resuscitation and end of life care

### 9.1 Resuscitation

F1 outcomes
<ul style="list-style-type: none"><li>• Is trained in immediate life support (ILS or equivalent) and paediatric life support if working with children</li><li>• Knows how to initiate and respond to a crash call</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Is trained in advanced life support (ALS or equivalent)</li><li>• Initiates ALS resuscitation and leads the team where necessary</li></ul>

#### Competences

- Recognises and manages the critically ill and peri-arrest patients
- Takes an active role in a team providing immediate life support, advanced life support and basic paediatric life support (for doctors working with infants and children)
- Is trained:
  - o to the standard of immediate life support (ILS or equivalent)
  - o in advanced life support (ALS or equivalent)
  - o in basic paediatric life support (for doctors working with infants and children)
  - o in the use of a defibrillator
- Knows where resuscitation equipment is located.

### 9.2 End of life care and appropriate use of Do Not Attempt Resuscitation (DNAR) orders/advance decisions

F1 outcomes
<ul style="list-style-type: none"><li>• Understands the principles of providing high quality end of life care including the use of DNAR orders as outlined in <i>Treatment and care towards the end of life: good practice in decision making</i> (GMC, 2010)</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Takes part in discussions regarding end of life care and DNAR orders</li><li>• Uses the local protocol for deciding when not to resuscitate patients</li></ul>

#### Competences

- Understands the value of 'diagnosing dying'
- Prioritises symptom control as part of end of life care
- Understands where and how to access specialist palliative care services
- Demonstrates an awareness of Advanced Care Planning in end of life care and the times when it may be appropriate
- Discusses patients' needs and preferences regarding end of life care wherever possible

# Patients with long-term conditions

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- Understands the ethics of transplantation and identifies potential donors to senior medical staff
- Discusses and plans for preferred place of death wherever possible
- Takes part in a multidisciplinary approach to end of life of life care utilising tools such as the Liverpool Care Pathway
- Understands the importance of adequate discussion and documentation of DNAR orders
- Describes the criteria for issuing DNAR orders and the level of experience needed to issue them
- Discusses DNARs with the multidisciplinary team, the patient, long-term carers (both medical and non-medical) and relatives
- Understands the accountability of the responsible clinician when a DNAR decision is made
- Understands the role of the individual and the family in the communication of DNAR orders
- Recognises actual and potential conflicts between patients and their relatives
- Recognises and acts appropriately when DNAR decisions are challenged/conflicts arise between interested parties
- Facilitates the regular review of DNAR decisions.

# Patients with long-term conditions

## 10. Patients with long-term conditions

### 10.1 Manages patients with long-term conditions

F1 outcomes
<ul style="list-style-type: none"><li>Accurately re-prescribes long-term medications checking for side effects and significant interactions in the context of the current illness (see <i>Good Clinical Care: Safe Prescribing, 2008</i>)</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>Manages long-term conditions during episodes of acute care</li></ul>

#### Competences

- Reviews acute presentation in context of long-term disease progression and symptom control
- Recognises new complications of long-term illness(es)
- Anticipates when management of a long-term problem may impact on treatment of an acute problem and vice versa e.g. drug interactions, fluid balance
- Listens to patients and respects their views about their treatment
- Demonstrates the knowledge and skills to care for patients with long-term diseases during their in-patient stay
- Reviews long-term drug regime and considers modifying treatment
- Recognises the interplay between long-term physical illness, psychological factors and mental disorder, and the implications for both management and outcomes
- Recognises co-morbidity and its effects on in-patient and community care
- Explains the impact of current condition on pre-existing long-term conditions and co-morbidity to patients, carers and colleagues
- Understands the role of other healthcare professionals in the management of long-term diseases
- Recognises the need for physiotherapy and occupational therapy for inpatients with long-term mobility problems
- Understands how the home and work environment impacts on patients' long-term conditions, including the implications of unemployment.

### 10.2 Supporting patient decision making

F1 outcomes
<ul style="list-style-type: none"><li>Encourages and assists patients to make decisions about their care</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>Works with the MDT to plan care for those with long-term illness</li><li>Encourages and ensures evaluation of patients' capacity to self-care</li></ul>

# Patients with long-term conditions

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## Competences

- Recognises and promotes self care for patients where appropriate
- Arranges support when it is necessary, notably when an acute problem is superimposed on a long-term illness
- Promotes and encourages involvement of patients in appropriate support networks, both to receive support and give support to others
- Recommends agencies who can provide advice/information on both medical and non-medical issues
- Understands criteria for specialist rehabilitation, care home placement and respite care and arranges appropriate assessment.

## 10.3 Nutrition

F1 outcomes
<ul style="list-style-type: none"><li>• Takes a basic nutrition history and considers this in planning care</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Ensures adequate nutrition (including nutritional supplements) for patients with acute illness and long-term conditions</li></ul>

## Competences

- Recognises nutritional disorders are common in patients with long-term conditions
- Performs basic nutritional screen and recognises patients with potential for nutritional deficiencies and considers this in planning care
- Formulates a plan for investigation and management of weight loss or weight gain
- Demonstrates the knowledge, skills, attitudes and behaviours to assess patients' basic nutritional requirements
- Recognises major nutritional abnormalities and eating disorders and establishes a management plan, where relevant with other healthcare professional input
- Works with other healthcare professionals in addressing nutritional needs and communicating these during care planning
- Makes nutritional care part of daily practice
- Considers the additional effects of long-term ill-health on nutritional status and the effect of poor nutrition on long-term health.

# Patients with long-term conditions

## 10.4 Discharge planning

F1 outcomes
<ul style="list-style-type: none"><li>Recognises and records when patients are medically fit for discharge</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>Produces a competent, legible discharge summary that identifies principle diagnoses, key treatments/interventions, discharge medication and follow-up arrangements in a timely manner</li></ul>

### Competences

- Starts planning discharge from the time of admission, including early referral to the appropriate members of the multidisciplinary team
- Considers long-term conditions in the discharge process of patients
- Takes an active part in discharge planning meetings
- Recognises the potential impact of long-term conditions on patients, family and friends
- Understands the impact on the activities of daily living on long-term conditions e.g. epilepsy and communicates these to the patients and carers
- Understands the family dynamics and socio-economic factors influencing success of discharge
- Liaises and communicates with patient, family and carers and primary care teams
- Leads discharge planning and communications with primary care and other agencies, for example the Citizens Advice Bureau, and is aware of the needs of carers
- Ensures that the necessary environmental adaptations and care plans are in place before discharge
- Arranges secondary care (or primary care) follow-up when appropriate.

## 10.5 Health promotion, patient education and public health

F1 outcomes
<ul style="list-style-type: none"><li>Explains to patients the possible effects of lifestyle, including the effects of diet, nutrition, smoking, alcohol and drugs (separately and in combination)</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>Recognises and uses opportunities to prevent diseases and promote health</li></ul>

### Competences

- Demonstrates awareness of the importance of lifestyle on long-term illness and on the presentation and course of an individual patient episode
- Demonstrates the ability to educate colleagues and medical students on the impact of lifestyle and long-term illness on all aspects of a patient's journey through a disease episode
- Advises patients on correct use of medicines, including how to recognise emergence of serious adverse effects
- Identifies potential 'ready to quit' smokers

# Patients with long-term conditions

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- Advises on smoking cessation and supportive measures
- Advises appropriate drinking levels or drinking cessation
- Describes the implications of the wider determinants of health including:
  - biohazards
  - UV radiation especially the harmful effects of sunlight
  - lack of exercise
  - weight management
  - employment
  - smoking
  - alcohol intake
- Advises appropriate:
  - vaccination programmes, including those for children
  - cancer screening e.g. breast, cervical, bowel
  - well man/women clinics
- Describes the impact of inequality and deprivation on the health of patients and populations
- Recognises the impact of chronic disability on patients during an acute illness or injury.



# Investigations

## 11. Investigations

F1 outcomes
<ul style="list-style-type: none"><li>• Ensures that specimens and requests for investigation have the correct patient details</li><li>• Requests/arranges/interprets appropriate ECG, laboratory tests and other investigations to aid diagnosis</li><li>• Ensures that test results are from the correct patient</li><li>• Interprets basic radiographs (chest, abdomen and bones) and identifies correct and incorrect positions of nasogastric tubes</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Maintains and improves their interpretive skills across an increasing range of investigations and clinical outcomes</li></ul>

### Competences

- Explains to patients the risks, possible outcomes and implications of investigation results, gains informed consent and discusses test results when appropriate
- Recognises that requesting investigations, then interpreting and acting upon their results is a crucial element of modern medical practice
- Requests investigations appropriate for patients' needs in accordance with local and national guidance to optimise the use of resources
- Seeks out, records and relays results in a timely manner
- Plans/organises appropriate further investigations to aid diagnosis and/or inform the management plan
- Provides concise, accurate and relevant information and understands the diagnostic question when requesting investigations
- Understands what common tests (Table 1) and procedures entail, the diagnostic limitations and contraindications, in order to ensure correct and relevant referrals/requests
- Interprets the results correctly within the context of the particular patient/presentation e.g. plain radiography in a common acute condition
- Helps and directs colleagues to order and interpret appropriate tests and investigations
- Labels all pathology samples/tubes/requests correctly
- Knows how biological samples should be sent for histological examination, including the sample-specific quality issues that help the pathologist to make an accurate diagnosis
- Recognises that ionising radiation, magnetic fields and intravascular contrast can be harmful and is able to justify radiation exposure (see *UK Ionising Radiation (Medical Exposure) Regulations 2000*)
- Reviews imaging and pathology reports
- Prioritises importance of investigation results
- Knows when a post mortem should be requested and the relationship of this process to death certification and the work of the coroner/procurator fiscal
- Obtains consent for a post mortem examination.

# Investigations

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Table 1. Commonly requested investigations

The following investigations are commonly requested or required during a hospital admission or as an outpatient or in general practice.

## Laboratory tests

- Haematological
  - Full blood count
  - Coagulation studies
  - Inflammatory markers
- Biochemical
  - Urea and electrolytes
  - Blood glucose
  - Cardiac markers
  - Liver function tests
  - Amylase
  - Calcium and phosphate
  - Lactate
  - Arterial blood gases
- Pathological
  - Histopathological/cytopathological, microbiological sampling including blood cultures (obtained by correct aseptic technique), tissue (including biopsies and surgical specimens) and pus
  - Post mortem examination
- Bedside tests (tests performed in proximity to the patient)
  - 12 lead ECG
  - Tests of respiratory function: peak flow, spirometry
  - Urinalysis
- Imaging tests
  - Plain radiographs e.g. chest X-ray, abdominal X-ray
  - Trauma radiography
  - Cross sectional imaging e.g. ultrasound, CT and MRI

# Procedures

## 12. Procedures

F1 outcomes
<ul style="list-style-type: none"><li>• Competently performs and, when sanctioned by a supervisor, teaches medical students in the core procedures listed (see Table 2) either in the workplace or on simulated patients</li></ul>
F2 outcomes (in addition to F1)
<ul style="list-style-type: none"><li>• Maintains and improves skills in the core procedures e.g. reliably able to perform venous cannulation in the majority of patients in more challenging circumstances such as during resuscitation</li><li>• Demonstrates extension of the range of procedures they can perform</li></ul>

Table 2. Commonly requested investigations

<ul style="list-style-type: none"><li>• Venepuncture</li><li>• IV cannulation</li><li>• Preparation and administration of IV medication and injections and fluids</li><li>• Arterial puncture in an adult</li><li>• Blood culture (peripheral)</li><li>• IV infusion including the prescription of fluids</li><li>• IV infusion of blood and blood products</li><li>• Injection of local anaesthetic to skin</li><li>• Subcutaneous injection</li><li>• Intramuscular injection</li><li>• Perform and interpret an ECG</li><li>• Perform and interpret peak flow</li><li>• Urethral catheterisation in adult females and males</li><li>• Airway care including simple adjuncts*</li></ul> <p>* Especially suited for simulated models/manikins</p>
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### Competences

For each procedure foundation doctors should know the indications and contraindications and be able to:

- explain the procedure to patients (including possible complications) and gain valid informed consent, refer to *Consent: patients and doctors making decisions together* (2008)
- prepare the required equipment, including a sterile field
- position the patient and prescribe/administer premedication/sedation in certain patients, (e.g. for chest drain insertion) with referral to senior colleagues and/or the anaesthetist if required
- adequately prepare the skin where relevant, including giving local anaesthetic
- recognise, record and be able to undertake emergency management of common complications

# Procedures

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- safely dispose of equipment, including sharps
- document the procedure, including the labelling of samples and giving instructions for appropriate aftercare/monitoring
- under supervision perform procedures linked to a specialty attachment, when and if attached to that specialty, for example:
  - o aspiration of pleural fluid or air in emergency or respiratory medicine
  - o skin suturing in emergency medicine or surgery
  - o fracture manipulation in orthopaedics and emergency medicine
  - o insertion of a central venous catheter in critical care or similar environment
  - o insertion of nasogastric tube
  - o insertion of a speculum in gynaecology
  - o bone marrow aspiration in haematology
  - o lumbar puncture in medicine/neurology
- teach other healthcare workers and medical students the procedure when proficient
- assists other colleagues with difficult procedures.

# Learning and teaching

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Learning and teaching occurs both in the workplace and in protected teaching time. Doctors are expected to learn both from and through teaching. Learning to teach is an important element of this. Workplace learning is both experiential and in the form of supervised learning events (SLEs). Foundation doctors are encouraged to engage in reflective practice and self-directed learning from patients, clinical opportunities, books, journals and electronic learning materials, including e-Learning for Healthcare (e-LfH) as described in the *Foundation Programme Curriculum 2012 Resource*.

Foundation doctors need to recognise that whilst protected teaching time is an important part of their education, it is the workplace that offers the majority of clinical and professional learning opportunities. It is also critically important that foundation doctors recognise that they have professional and personal responsibility for their own learning. This includes attending structured educational sessions and undertaking SLEs wherever possible. Postgraduate deaneries, foundation schools, consultant and general practitioner trainers all have roles but these should be seen as an adjunct to that personal responsibility.

Foundation doctors should also learn by observing how other healthcare professionals (role models) perform both as individuals and as members of clinical teams. They should learn about modes of engagement and interaction with patients and other professionals, as well as observing practical skills and how formal knowledge is applied.

Foundation doctors should reinforce learning by thinking about both good and bad aspects of care with emphasis on how they might perform in the future in a similar situation. Reflection on their learning experiences should be recorded in the e-portfolio as part of their evidence of commitment to the educational process, and may be reviewed with/by clinical and educational supervisors.

Although some clinical experiences may seem repetitive, they still present a learning opportunity. Revisiting aspects of practice remains an integral component of the spiral curriculum that underpins foundation training. It is important to appreciate and experience variation within common conditions. This will create greater expertise and allow foundation doctors to progressively take more management responsibility in acute and long-term care.

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## Clinical learning experiences

Foundation doctors and their trainers should recognise the importance of maximising the wide variety of learning opportunities in the clinical workplace and undertake SLEs to capture this. These must be appropriate to the foundation doctor's level of experience and the nature of learning opportunities afforded by their current working environment (Table 3).

Table 3. Work-based learning and teaching opportunities

- |  |
|--|
| <ul style="list-style-type: none"><li>• Work as a medical professional, including clinical practice, meetings and documentation</li><li>• Supervised learning events (SLEs)</li><li>• Accounts by patients, service users and carers of their experiences</li><li>• Analysis of care scenarios supported by literature reviews</li><li>• Quality improvement and audit projects</li><li>• Audio/video recording of personal practice or a colleague's practice</li><li>• Computer-controlled simulator</li><li>• Discussion of one's own or another's practice</li><li>• E-learning: e-LfH, BMJ Learning, <i>FP Curriculum 2012 Resource</i></li><li>• Group discussion of typical cases</li></ul> |
|--|

# Learning and teaching

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- Mock assessments
- Narrative of one's own or someone else's case
- Observation of someone else's work and practice
- Review of clinical guidelines or protocols
- Review of patients' case notes (individual or team)
- Simulated patients and/or colleagues
- Skills laboratory
- Undertaking a supervised leadership activity such as leading the multi-disciplinary team meeting

Source: *Modified from Fish and Coles (2005)*

The learning opportunities and experiences available vary between placements and rotations. It is recommended that foundation school directors (FSDs) map their rotations to the Curriculum and familiarise themselves with areas in the Curriculum which may require additional input to deliver (Table 4).

Table 4. Examples of potential difficulties related to delivery of the Curriculum

- Organisation and allocation of work by an F2 within the team during placements where there is no F1 doctor
- Exposure to managing long-term ill health in rotations which do not include general practice, community medicine or outpatient clinics
- Exposure to acutely unwell patients in rotations which do not include at least four months in Acute/Emergency Medicine
- Assessment of competence in an acute setting
- ALS/equivalent course
- Senior supervision and discussion of discharge planning, discharge summaries and ongoing medication (drugs to take out/away from hospital)
- Adequate demonstration of progress in relationships with patients and communications skills

Foundation school directors should consider alternative mechanisms to cover elements of the Curriculum which may not be encountered in daily practice.

These could be included in programmed educational activities where emphasis might be placed on topics which are challenging to deliver locally, or on concepts which are particularly important or difficult to understand. Whenever possible, novel opportunities should be used to deliver these (Table 5).

Table 5. Additional opportunities to deliver and assess curriculum coverage

- Simulation training to demonstrate practical, organisational and team working ability
- Supervised clinical practice directed at key areas
- Formal teaching programme tailored to the local educational needs
- Demonstration of appropriate learning/assessment online using local and national resources such as e-Learning for Healthcare (e-LfH)

# Learning and teaching

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## How practical procedures are learnt

Practical procedures start to be learnt as undergraduates and may be a focus during clinical assistantships in the final year. It is the expectation that medical students and foundation doctors learn procedural skills on simulated models/manikins prior to undertaking the procedure on patients. Students and doctors are encouraged to recognise that the ability to perform a practical procedure increases with time, repetition and experience and that they will be encouraged to demonstrate progression of their ability through direct observational procedural skills (DOPS) and reflective learning.

The following steps may be taken:

- Reading the theory, or studying virtual training packages on the internet or DVD
- Using a skills laboratory (where available)
- Learning in simulation centres with simulated patients
- Observing first hand
- Being observed doing the procedure by a competent practitioner with relevant experience of the procedure.

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## Technology enhanced learning

Evidence from recent UK studies has shown that simulation facilities and e-learning provides foundation doctors with valuable opportunities to deepen their understanding of the importance of not only practical skills, but also communication skills, human factors and teamwork.

As part of a managed learning process and where appropriate, foundation doctors should learn skills in a simulated environment and using other technologies. They should be judged to be safe in this environment before they undertake a supervised procedure on a patient.

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## Teaching

Foundation doctors will be expected to acquire and develop the skills needed to deliver teaching and mentoring effectively. This includes understanding the basic principles of adult learning. They must recognise that teaching skills also apply to interactions with patients/relatives e.g. when explaining illness to patients/relatives/carers. The acquisition of teaching skills should be documented in the e-portfolio and feedback should be sought on the quality of teaching using the 'developing the clinical teacher' SLE as well as from those receiving the teaching.

Consideration should be given to developing effective presentation styles including approaching teaching sessions from the perspective of the learner. This should include reflection on the learner/s' (including patients/relatives) needs. They should understand different approaches such as small group and large group learning and when each is most effective. When teaching groups, foundation doctors should demonstrate appropriate use of teaching aids and organise the environment to optimise interaction. They should allow time/space for others to express their views and also facilitate group discussion. Additional opportunities to develop presentation skills exist in departmental meetings/audit/grand/ward rounds.

Doctors must learn to give and receive feedback and perform assessments. Foundation doctors will contribute to the assessment or review of students and other colleagues with whom they work. They need to understand the underlying principles of coaching and theory of feedback (e.g. Pendleton model). They should always observe a learner's performance before commenting on any aspect of it, and then give relevant feedback in a structured, sensitive, constructive and positive way.

# Learning and teaching

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Foundation doctors may take on a supervised educational role, for example in teaching and supervising medical students on a ward or in an outpatient setting. When teaching they must always treat patients and other learners with respect, including seeking patients' permission before any teaching session involving them. Doctors should treat requests for help positively and help those they are teaching to become progressively more independent.

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## Study leave during foundation training

Foundation year 1 (F1) doctors do not have access to study leave, although there may be opportunities for 'career taster' sessions in F1. Refer to the Reference Guide.

Foundation year 2 (F2) doctors will be encouraged to take study leave to support their learning in relation to the Curriculum (refer to the Reference Guide). This might include:

- attending courses relevant to the Foundation Programme e.g. to achieve ALS training or its equivalent
- sampling other 'taster' career alternatives that were not available within their F1 rotation e.g. public health, laboratory-based specialties etc.

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## Support for learning

Local education providers (LEPs) will provide details of the educational supervisor(s) and clinical supervisors to the foundation doctor (refer to Appendix B: Responsibilities of trainers).

Within any placement an individual healthcare professional is unlikely to build up a coherent picture of the competences, let alone performance of an individual foundation doctor. Whenever possible the named clinical supervisor will seek information from colleagues who encounter the doctor in clinical practice. These colleagues will function as a Placement Supervision Group, commenting on the foundation doctor's performance in the workplace. They will give feedback to the clinical supervisor to inform the end of placement report. Not every placement will offer contact with multiple senior doctors and in some cases the foundation doctor will only work with one or two doctors. In these cases the pool of health care professionals making the assessment of performance will be smaller, but conversely, the degree of interaction and number of interactions between foundation doctor and trainer will be expected to be greater.

The Placement Supervision Group will be responsible for helping the clinical supervisor form a balanced judgement of a doctor's performance, based on observation in the workplace and engagement in the educational process. Such an approach will prevent any individual having undue influence over a doctor's progression. To ensure fairness and equality of opportunity, all assessments will be subject to monitoring.

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## Initial appraisal and educational agreements

When foundation doctors start in a new placement, they must arrange an early meeting with both their educational and clinical supervisors, where possible, before the placement commences. This is the responsibility of the foundation doctor. If the foundation doctor is finding difficulty in arranging this meeting, the LEP will provide a back-up mechanism to ensure that this meeting takes place. This is an essential starting point for negotiating the educational goals and discussing learning opportunities, the assessment process and use of the e-portfolio. The goals should take into account individual learning needs and difficulties.

*The educational agreement and related learning plan must be recorded in the e-portfolio.*



# Supervised learning events (SLEs) and assessment

The Foundation Programme requires that all foundation doctors complete supervised learning events (SLEs) and formal assessments as evidence of their professional development.

Different tools are used for SLEs and assessments (Tables 6 and 7).

**Table 6. Recommended minimum number of SLEs per placement**

Supervised learning event	Recommended minimum number per placement*
Direct observation of doctor/patient interaction: Mini-CEX DOPS	3 or more Optional to supplement mini-CEX
Case-based discussion (CBD)	2 or more
Developing the clinical teacher	1 or more

\*based on a clinical placement of four month duration

**Table 7. Frequency of assessments**

Assessments	Frequency
E-portfolio	Contemporaneous
Core procedures	Throughout F1
Team assessment of behaviour (TAB)	Once in first placement in both F1 and F2, optional repetition
Clinical supervisor end of placement report	Once per placement
Educational supervisor end of placement report	Once per placement
Educational Supervisor's End of Year Report	Once per year

# Supervised learning events (SLEs)

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Supervised learning events represent an important opportunity for learning and improvement in practice, and are a crucial component of the Curriculum. It is the duty of the foundation doctor to demonstrate engagement with this process. This means undertaking an appropriate range and number of SLEs and documenting them in the e-portfolio. The clinical supervisor's end of placement report will draw on the evidence of the foundation doctor's engagement in the SLE process. Participation in this process, coupled with reflective practice, is a way for the foundation doctor to evaluate how they are progressing towards the outcomes expected of the programme which are specified in the Curriculum.

## Purpose of the SLE

The purpose of the SLE is to:

- highlight achievements and areas of excellence
- provide immediate feedback and suggest areas for further development
- demonstrate engagement in the educational process.

## SLE methodology

SLEs are designed to help foundation doctors improve their clinical and professional practice. They do not need to be planned or scheduled in advance and should occur whenever a teaching opportunity presents itself. The SLE should be used to stimulate immediate feedback and to provide a basis for discussion with the clinical and/or educational supervisor.

Foundation doctors are expected to demonstrate improvement and progression during each placement and this will be helped by undertaking frequent SLEs. Therefore, foundation doctors should ensure that SLEs are evenly spread throughout each placement. Improvement in clinical practice will only happen if regular SLEs lead to constructive feedback and subsequent review of and reflection on progression. For this to occur some targeted SLEs should specifically be related to previous feedback and developmental targets. This may be facilitated if the foundation doctors agree the timing and the clinical case/problem with the trainers in advance. However, unscheduled SLEs can also be focused on specific needs.

SLEs use the following tools:

- Mini-clinical evaluation exercise (mini-CEX)
- Direct observation of procedural skills (DOPS)
- Case based discussion (CBD)
- Developing the clinical teacher.

A different teacher/trainer should be used for each SLE wherever possible, including at least one at consultant or GP principal level per placement. The educational or clinical supervisor should perform an SLE. The SLE must cover a spread of different acute and long-term clinical problems (Table 8) and discussion should include the management of long-term aspects of patients' conditions. Teachers/trainers should have sufficient experience of the area under consideration, typically at least higher specialty training (with variations between specialties); this is particularly important with case based discussion.

# Supervised learning events (SLEs)

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Table 8: Illustrative problems to be considered and sampled by SLEs

- Airway problems
- Breathing problems
- Circulation problems
- Gastrointestinal problems
- Haematological problems
- Infection/inflammatory/immunity problems
- Musculoskeletal/locomotor problems
- Neurological and visual problems
- Obstetric and gynaecological problems including fertility
- Oncological problems
- Psychiatric/psychological problems
- Renal/Urological problems
- Trauma/injury
- Pain
- Long-term conditions
- Communication
- Breaking bad news
- Apologising

## Responsibility

The foundation doctor, with the support of the supervisor(s), is responsible for arranging SLEs and ensuring a contemporaneous record in the e-portfolio.

Trainers:

- must be trained in giving feedback, understand the role of the tool being used and be competent in the competence they are teaching, supervising and assessing
- should usually be supervising consultants, GP principals, doctors who are more senior than an F2 doctor, experienced nurses (band 5) or allied health professional colleagues.

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## Educational and development tools

### Direct observation of doctor/patient encounter

Two tools are used to give feedback after observation of doctor/patient encounters:

- Mini-clinical evaluation exercise (mini-CEX)
- Direct observation of procedural skills (DOPS).

Foundation doctors are expected to undertake directly observed encounters in every placement. They are required to undertake a **minimum of NINE directly observed encounters per annum** in both foundation year 1 (F1) and in foundation year 2 (F2). At least six of these encounters each year should use mini-CEX.

# Supervised learning events (SLEs)

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## i) Mini-clinical evaluation exercise (mini-CEX)

This is an SLE of an observed clinical encounter. Mini-CEX must not be completed after a ward round presentation or when the doctor/patient interaction was not observed.

- Foundation doctors should complete a minimum of six mini-CEX in F1 and another six in F2. These should be spaced out during the year with at least two mini-CEX completed in each four month period
- There is no maximum number of mini-CEX and foundation doctors will often achieve very high numbers of SLEs recognising the benefit they derive from them.

## ii) Direct observation of procedural skills (DOPS)

The primary purpose of DOPS in foundation is to provide a structured checklist for giving feedback on the foundation doctor's interaction with the patient when performing a practical procedure.

- Foundation doctors may submit up to three DOPS in one year as part of the minimum requirements for evidence of observed doctor-patient encounters
- Different assessors should be used for each encounter wherever possible
- Each DOPS could represent a different procedure and may be specific to the specialty (NB: DOPS may not be relevant in all placements)
- Although DOPS was developed to assess procedural skills, its purpose in foundation is to give feedback on the doctor/patient interaction
- There is no maximum number of DOPS and foundation doctors will often achieve very high numbers of SLEs recognising the benefit they derive from them.

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## Supervised learning events which take place remote from the patient

Two tools are used to give feedback on events which take place remote from the patient:

- Case-based discussion (CBD)
- Developing the clinical teacher.

## iii) Case-based discussion (CBD)

This is a structured discussion of a clinical case managed by the foundation doctor. Its strength is investigation of, and feedback on, clinical reasoning.

- A minimum of six CBDs should be completed each year with at least two CBDs undertaken in any four month period
- Different teachers/trainers should be used for each CBD wherever possible
- There is no maximum number of CBDs and foundation doctors will often achieve very high numbers of SLEs recognising the benefit they derive from them.

## iv) Developing the clinical teacher

This is a tool to aid the development of a foundation doctor's skill in teaching and/or making a presentation and should be performed at least once a year. The foundation doctor will be encouraged to develop skills in preparation and scene-setting, delivery of material, subject knowledge and ability to answer questions, learner-centredness and overall interaction with the group.

# Assessment

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Foundation doctors are expected to demonstrate achievement in each outcome described in the Curriculum. They are not expected to demonstrate achievement of every single competence. The assessment process is not designed to rank the performance of foundation doctors.

Several forms of assessment will be used:

## i) E-portfolio

The totality of engagement in populating the various domains in the e-portfolio will be used as a method of assessment of the foundation doctor's success in achieving the outcomes described in the Curriculum.

## ii) Core procedures

The GMC requires demonstration of competence in a series of procedures in order for a provisionally registered doctor with a licence to practise to be eligible for full registration.

It is a requirement that the foundation doctor provides evidence within the e-portfolio of satisfactory performance of each core procedure at least once during foundation year 1 (F1). By the end of F1, the foundation doctor should be able to competently perform and teach undergraduates these procedures.

The core procedures from F1 do not need to be repeated in foundation year 2 (F2), but evidence of the F1 sign off is required for successful completion of the Foundation Programme. It should also be recognised that with practice, the foundation doctor is expected to demonstrate continuing improvement of skills in whichever procedure they perform.

## iii) Team assessment of behaviour (TAB)

This is a type of Multi-Source Feedback, previously known as 360 degree assessment.

In addition to TAB, foundation doctors have a personal responsibility to make self-assessment an integral part of their professional life. It is good educational practice for this to be stated clearly, and discussed fully during induction.

Prior to a foundation doctor inviting raters to contribute to the TAB process it is mandatory that they themselves complete a self-assessment of behaviour (self-TAB). This will include reflection on their performance.

TAB comprises collated views from a range of multi-professional colleagues. It is mapped to the self-assessment tool with identical sections.

- **TAB must** take place at least once a year. Deaneries/foundation schools have the option of increasing the frequency
- It is suggested that both F1 and F2 TAB be taken in the last month of the first placement during the year. If there are significant concerns about any foundation doctor, TAB should be repeated. Deaneries have the option of altering the periodicity of TAB to satisfy local needs
- For each assessment, the foundation doctor with their educational supervisor should agree 15 raters/assessors. A minimum of 10 returns are required. No other foundation doctor can be a rater.

The required mix of raters/assessors must include at least two of each of the following:

- Doctors more senior than F2, including at least one consultant or GP principal
- Senior nurses (band 5 or above)
- Allied health professionals
- Other team members including ward clerks, secretaries and auxiliary staff.

# Assessment

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Following TAB, foundation doctors should reflect on any sections in which there is variance between their self rating and that of their assessors. They should discuss significant discrepancies with their educational supervisor.

## iv) End of placement reports

There are two end of placement reports:

### a) clinical supervisor's end of placement report

### b) educational supervisor's end of placement report

The clinical supervisor's end of placement report describes performance of the foundation doctor in the workplace. The educational supervisor's report incorporates the information contained in the clinical supervisor's report and in addition includes information from the e-portfolio.

If the educational and clinical supervisors are one and the same, then the educational supervisor will be responsible for the sections that are usually covered in the clinical supervisor's report.

### a) Clinical supervisor's end of placement report

Towards the end of each placement, the foundation doctor and clinical supervisor will meet to complete a summative assessment of the foundation doctor's overall performance and progress in the placement.

The clinical supervisor's report should comment specifically on:

- any noteworthy aspect of this foundation doctor's performance
- any concerns regarding this foundation doctor's performance
- the foundation doctor's appropriate participation in the agreed educational process
- evidence of the foundation doctor's personal and professional development as a result of feedback and reflection.

The clinical supervisor should seek and record evidence from the Placement Supervision Group to corroborate each of the above. The names of those contributing evidence on performance will be recorded in the report.

The outcome of the final assessment discussion should be agreed by both the foundation doctor and the clinical supervisor and recorded in the doctor's e-portfolio clinical supervisor's end of placement report.

Where the educational supervisor is different from the clinical supervisor, there should be a continuous, appropriate, and timely flow of information as suggested above. The report should detail any outstanding issues that still need to be addressed. Refer to section 10 of the Reference Guide.

### b) Educational supervisor's end of placement report

The educational supervisor's end of placement report requires review of the clinical supervisor's report along with the evidence provided within the e-portfolio and any other source.

Whilst engagement with supervised learning events (SLEs) and evidence of curriculum coverage will be taken into account, the overall judgement will include a triangulated view of the foundation doctor's day to day work performance, which will include their participation in, and attendance at, educational activities, appraisals, the learning process and recording of this in the e-portfolio.

The outcome of the final assessment discussion should be agreed by both the foundation doctor and the educational supervisor and recorded in the doctor's e-portfolio educational supervisor's end of placement report.

*Approved on 4 March 2014*

# Assessment

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## v) Educational Supervisor's End of Year Report

Placement reports are drawn together by the educational supervisor in an Educational Supervisor's End of Year Report which will form the basis of the foundation training programme director/tutor's (FTPD/Ts) recommendations regarding satisfactory completion of F1 and the Foundation Programme as a whole.

The Educational Supervisor's End of Year Report is an overall professional assessment and judgement of the foundation doctor.

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## Assessment differences between F1 and F2

The decision about whether or not a foundation doctor has met the required standard for satisfactory completion of F1, or the Foundation Programme as a whole, will involve an overall judgement by the educational and clinical supervisors supported by the Placement Supervision Group established within the LEP.

### Foundation year 1 (F1)

The outcomes recorded following clinical performance reviews and evidence of engagement in the educational process will feed into the overall performance report at the end of the year (the Educational Supervisor's End of Year Report). This report confirming overall satisfactory performance of the F1 doctor will inform the medical school as to whether they should complete and issue the GMC Certificate of Experience. Once the certificate is issued, the foundation doctor is eligible to apply for full registration with the GMC. The GMC expects satisfactory achievements in all domains set out in *The Trainee Doctor* (2011) and reproduced in the *Foundation Programme Curriculum* syllabus outcomes.

### Foundation year 2 (F2)

The overall judgement of satisfactory completion of F2 will allow the foundation doctor to be eligible to enter core, specialty or general practice training. This judgement will include an assessment of a foundation doctor's ability to take on increasing levels of responsibility, and will be marked by the issuing of a Foundation Achievement of Competence Document (FACD). Refer to the Reference Guide.

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## Lack of progress

Most foundation doctors should achieve the required F1 outcomes by the end of their first year, and the F2 outcomes by the end of their second year (or whole time equivalent). The actual duration of foundation training will depend on whether the foundation doctor is working full time or less than full time.

Deaneries/foundation schools have systems in place to help foundation doctors who may need additional or targeted support. Such doctors may be identified by:

- concerns raised by foundation doctors themselves, which might include problems relating to their training or assessments
- information transferred from undergraduate medical schools (refer to COPMeD, MSC and GMC guidance)
- periods of prolonged or repeated absence (refer to the Reference Guide for further detail)
- reluctance/failure to take part in educational processes
- reluctance/failure to engage in the appraisal process
- concerns about day to day clinical work raised by educational and/or clinical supervisors (directly or on the basis of report by other HCPs)
- serious incidents/events/complaints from patients, colleagues or carers.

Approved on 4 March 2014

# Assessment

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Wherever possible, these issues must be discussed with the foundation doctor. The educational supervisor should follow the Reference Guide and any additional local processes and seek early advice when necessary.

Doctors who do not make progress may need additional and targeted education and training, with further specifically targeted assessments undertaken to determine progress. Training may be extended for up to a maximum of one year at F1 or one year at F2 (or equivalent for foundation doctors working less than full time) at the discretion of the local deanery.

If there is still inadequate progress following additional and targeted support, then the doctor will be deemed to have failed that element of their foundation training. This means that they will have either failed to meet the requirements for satisfactory completion of F1 or satisfactory completion of F2. The deanery/foundation school in partnership with the graduating medical school must inform the GMC ([atukmanager@gmc-uk.org](mailto:atukmanager@gmc-uk.org)) about any doctor who fails to meet the requirements for satisfactory completion of F1 and will not be “signed off” as having attained F1 competency. Doctors failing to meet the requirements for satisfactory completion will not be eligible for full registration with the GMC, and will only be able to work in a rotation approved for training at F1 level. Doctors who do not satisfactorily complete F2 will not be issued with a FACD and will not be able to progress into core, specialty or GP training.

There is an appeals mechanism for foundation doctors who have not satisfied the requirements and/or are disputing judgements of performance. If an F1 doctor fails after a 12 month extension, the appeal would normally be held by the graduating UK medical school. If they did not graduate from a UK medical school, the appeal would be held by the deanery.

If an F2 doctor fails, the deanery/foundation school will consider the appeal. The deanery will also normally initiate career management discussions and may refer the foundation doctor to the National Clinical Assessment Service (NCAS). Further information can be found in the relevant section of the Reference Guide and in the *Standards for Training in the Foundation Programme* (in *The Trainee Doctor*, 2011).

Foundation doctors in Scotland have a different system and should refer to [www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk) for further information.

The employer is also responsible for assessing and determining the employability of a foundation doctor. A foundation doctor may not be deemed employable in a foundation placement or rotation where particular concerns or problems have been identified.

In such instances, the employer must inform the deanery/foundation school, and in normal circumstances an agreement would need to be reached over referral of the foundation doctor concerned to the GMC, so that the GMC can determine whether or not the foundation doctor can remain on the professional register. In most circumstances this would require referral to the GMC's Fitness to Practise procedures.



# Appendix A

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## Changes since 2010 and future development

The Curriculum has been extensively revised following the *Foundation for Excellence: An Evaluation of the Foundation Programme* report (2010) and *The Trainee Doctor* (2011).

This revision has been undertaken as an evolutionary process and has been performed with input and feedback from key stakeholders at all stages of the process. During the revision an executive group comprising representatives from the Academy of Medical Royal Colleges (AoMRC) Foundation Programme Committee, UK Foundation Programme Office (UKFPO) and General Medical Council (GMC) has met regularly to ensure that changes are deliverable and that the regulator is aware of the nature of the revisions to ensure that they are in keeping with regulatory requirements.

The *Foundation for Excellence: An Evaluation of the Foundation Programme* report (2010) highlighted many positive aspects of the Curriculum but also noted four particular areas of concern. Each of these is specifically addressed in this revision.

- **The purpose of foundation training:** A lack of clearly defined objectives of the Foundation Programme was identified. A statement of purpose clearly articulating the objectives of foundation training was developed by AoMRC, UKFPO and GMC. This statement has also been approved by the Medical Programme Board of Medical Education England.
- **The value of F2 training:** A lack of clarity regarding the expectations and outcomes from the second year of foundation training was expressed. This has been addressed in the purpose of training and also by clarifying throughout the syllabus the higher level of performance expected by F2 doctors. In particular there are high level descriptors indicating the outcomes expected from both F1 and F2 doctors for each of the sections of the Curriculum.
- **Long-term condition management:** The Curriculum was considered to concentrate too heavily on the care of the acutely ill patient. This has been addressed throughout the revision by seeking opportunities to recognise the interrelations of chronic ill health and acute disease and to develop skills in managing long-term conditions.
- **Assessments within the Foundation Programme:** The number and value of the workplace based assessments was a cause for concern. This has been addressed in two key ways. Firstly, it has been clarified how and by whom assessment will be performed at the end of each clinical placement and at the end of F1 and F2. Secondly, the use of “workplace based assessment tools” has been radically revised. These tools are now used as “supervised learning events” (SLEs). SLEs are purely developmental and not used for assessment.

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## Impact of these changes to the Curriculum

The overall layout of the new Curriculum will be instantly recognised by those familiar with the 2010 version. Users should be able to make a straightforward transition to use the 2012 Curriculum.

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## Structural changes in the Curriculum

Several noteworthy structural changes have been made including:

- A clear statement of purpose of the Curriculum has been included at the start of the document. This will also be published by UKFPO and MEE
- An executive summary has been added and sections on how to use the Curriculum, learning and teaching and assessment have been rewritten to encompass important changes

Approved on 4 March 2014

# Appendix A

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- The layout of the syllabus and competences has been revised comprehensively with outcome descriptors describing the performance expected from F1 and F2 headlining the competences in each section. This will simplify understanding of the objectives by foundation doctors, trainers and deaneries
- The order of the syllabus has been revised with subsections grouped into “professional” and “clinical”. The number of subsections has been distilled from 16 to 12. Grouping of competences has been rationalised accordingly and duplication reduced
- A record of ‘Core Procedures’ has been included and replaces the Logbook.

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## Assessment

The process of assessment within the Foundation Programme has been reviewed and thoroughly revised to clarify the process. Particular attention has been paid to:

- incorporating outcome descriptors describing clearly the performance expected of doctors at F1 and F2 level in each section of the syllabus
- specifying that ‘assessment of a doctor’s performance’ occurs at the end of each clinical placement and will be performed by the clinical/educational supervisor and will be informed by colleagues (Placement Supervision Group) who have observed the foundation doctor’s performance in the workplace.
- detailing the resources to be used to inform the assessment process
- developing a new end of placement form to reflect this
- specifying how the end of placement reports will be used to inform the head of school’s sign off of satisfactory completion of F1 and F2.

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## Workplace-based assessment

It is clearly stated that the ‘workplace-based assessment (WPBA) tools’ are not used for formal assessment (above). The developmental intent of encounters between senior trainers and foundation doctors is emphasised. This has been clarified by:

- introducing supervised learning events (SLEs) based on the WPBA tools. SLEs are to be used to help the foundation doctors progress by identifying strengths and areas for further professional development
- complete revision of the format of the SLE forms. Performance descriptors have been removed and comment is now via white box spaces for immediate feedback and developmental action points
- indicating that foundation doctors need to record reflection on each SLE
- indicating the need to engage in SLEs from early in each placement in order to maximise impact on professional development
- indicating that the timing and choice of subject for SLEs is to be chosen by trainer and foundation doctor together.

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## Syllabus and competences

There has been extensive review of the whole syllabus, in particular:

- Outcome descriptors have been added for each group of competences. These describe in high level terminology the performance expected from F1 and F2 doctors in each section of the syllabus

# Appendix A

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- Competences have been reviewed throughout. Similar competences have been grouped together in the most appropriate sections resulting in significant reduction in duplication
- The order of grouped competences has been revised into two sections: 'Foundation doctor as a professional and a scholar' and 'Foundation doctor as a safe and effective practitioner' for greater clarity
- The section on investigation and practical procedures has been rewritten in the same format as the remainder of the syllabus with outcome descriptors for F1 and F2
- The many opportunities to develop skills related to managing patients with long-term conditions are highlighted and the sub-section on patients with long-term conditions has been expanded substantially
- The importance of recognising potential victims of abuse has been added.

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## Minor Curricular Changes for 2014

In response to concerns regarding patient safety raised by SHOT UK (Serious Hazards of Transfusion) and NACT UK (National Association of Clinical Tutors) minor revisions have been made to the Curriculum. They relate to patient identification, blood transfusion and prescription of chemotherapy and immunosuppressant agents.

The changes can be found in the following sections:

- Section 7 Good Clinical Care now includes an additional subsection (7.2) entitled "Ensures Correct Patient Identification." This subsection introduces new outcomes and competences
- Section 7.5 "Prescribing" includes revised outcomes and competences
- Section 11 "Investigations" includes a new outcome.

There are no changes to the assessment system that underpins the quality of foundation training and education.

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## Future development of the Curriculum

It is a firm intention to develop a patient feedback tool for inclusion in the next edition of the *Foundation Programme Curriculum* and that patient feedback will be used to inform the assessment of foundation doctors as soon as the appropriate tools have been validated.

# Appendix B

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## Responsibilities of trainers

A trainer is an appropriately trained and experienced doctor who has responsibility for the education and training of foundation doctors in the clinical environment. A trainer provides appropriate supervision and is involved in and contributes to the learning culture. They provide feedback for learning and may have specific responsibility for assessment.

### Roles

When foundation doctors are learning in and from practice, it is important to understand that trainers' roles may overlap and differ in subtle ways. The roles of the educators needed to support learning activities include: advisor, appraiser, assessor, clinical supervisor, coach, co-learner, critical friend, educational supervisor, expert, facilitator, mentor, teacher, trainer and tutor. In these cases, supervision provides essential support. However:

- The needs of the learner should determine which role is adopted, and these roles will change over time and in different situations
- Skilled educators move in and among these roles according to identified need
- Enough time should be allocated to develop these roles and relationships
- Those involved should aspire to mutually negotiated and fair outcomes, but they should also recognise that supervision involves a power relationship
- Good educational practice requires a balance of the following aspects:
  - o support
  - o challenge
  - o clarification of the standards to be achieved
  - o clarification of the consequences of non-achievement.

Trainers may sometimes have specific positions in the Foundation Programme which include clinical and educational supervisors. Clinical and educational supervisors will be encouraged to identify learner-centred educational opportunities in the course of clinical work. *Liberating Learning* (2010) provides more detail on how this might be achieved in day to day practice.

### Educational supervisor

All foundation year 1 (F1) and foundation year 2 (F2) doctors **must have a named educational supervisor**.

A trainer is selected and appropriately trained to be responsible for the overall supervision and management of a specified foundation doctor's educational progress during a training placement or series of placements. The educational supervisor is responsible for the foundation doctor's educational agreement.

Only clinicians committed to and engaged in teaching and training foundation doctors should undertake the role. They must enable foundation doctors to learn by taking responsibility for patient management within the context of clinical governance and patient safety.

The named educational supervisor will be responsible for:

- ensuring that the programme is appropriate for foundation doctors' needs
- meeting with the foundation doctor at the beginning of each placement to discuss what is expected in the placement, learning opportunities available, the foundation doctor's learning needs and the foundation doctor's introduction to the Placement Supervision Group
- helping foundation doctors by reviewing their learning needs in the light of achieved goals

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# Appendix B

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- making a judgement on the collated assessments from clinical supervisors, trainers and other assessors who have worked with the foundation doctor (members of the Placement Supervision Group)
- reviewing the foundation doctor's learning e-portfolio
- conducting appraisals
- giving supportive feedback on the results of TAB
- meeting with the foundation doctor to assess whether they have met the necessary outcomes and complete an end of placement review form for each placement which will incorporate the clinical supervisor's report and information from the portfolio
- supporting the doctor through any difficulties
- telling the clinical director, head of service or medical director and those responsible for training, especially the clinical tutor, foundation programme director/tutor and foundation school director, of serious weaknesses in the foundation doctor's performance that have not been dealt with and any other problems an individual has with the training programme. The supervisor should tell the foundation doctor the content of any information about them that is given to someone else
- ensuring that all training opportunities meet the requirements of equality and diversity legislation
- giving appropriate handover to the next educational supervisor with the foundation doctor's knowledge.

## Clinical supervisor

Every foundation doctor will have a [named clinical supervisor](#) for each placement.

The named clinical supervisor will usually be the consultant or principal in general practice to whom a foundation doctor is directly responsible for their clinical work. There will be frequent contact between them. The clinical supervisor is selected and appropriately trained to be responsible for overseeing a specified foundation doctor's clinical work during a placement, providing constructive feedback and forming the summative judgement at the end of that clinical training placement. The doctor responsible for direct clinical supervision may change on a daily basis for each foundation doctor, but the named clinical supervisor will remain the same throughout each placement.

The named clinical supervisor is responsible for:

- guaranteeing suitable induction to the ward/department/practice
- meeting with the foundation doctor at the beginning of each placement to discuss what is expected in the placement and learning opportunities available. The foundation doctor's learning needs will also be discussed and the Placement Supervision Group be made known to the foundation doctor
- ensuring that the clinical experience available to the foundation doctor is appropriate and properly supervised.
- undertaking and facilitating SLEs
- monitoring, supporting and assessing the foundation doctor's day-to-day clinical and professional work
- providing regular feedback on the foundation doctor's performance. Ensuring that all training opportunities meet the requirements of equality and diversity legislation

# Appendix B

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- allowing the foundation doctor to give feedback on the experience, quality of training and supervision provided
- discussing serious concerns with the educational supervisor about a foundation doctor's performance, health or conduct
- seeking formal feedback from the Placement Supervision Group regarding the foundation doctor's progress
- completing the clinical supervisor's end of placement report (which can include recording achievements of outcomes and competences) at the end of the placement.

Some training schemes appoint an educational supervisor for each placement. The roles of clinical and educational supervisor may then be merged.

## Placement Supervision Group

The Placement Supervision Group consists of trainers nominated in each placement by the named clinical supervisor. Their observations and feedback will inform the clinical supervisor's end of placement report. The makeup of the Placement Supervision Group will vary depending on the placement, for example:

- Doctors more senior than F2, including at least one consultant or GP principal
- Senior nurses (band 5 or above)
- Allied health professionals
- In a general practice placement the faculty may be limited to one or two GPs.

The Placement Supervision Group is responsible for:

- observing the foundation doctor's performance in the workplace
- undertaking and facilitating SLEs
- providing feedback on practice to the foundation doctor
- providing structured feedback to the clinical supervisor.

## Local education providers (LEPs)

Local education providers (LEPs) must ensure that educational and clinical supervisors have support and resources which will include adequate time to undertake their training role. This will include training in equality and diversity.

# Appendix C

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## Ensuring quality in foundation programmes

The GMC is the UK competent authority with regard to EU legislation for undergraduate and postgraduate medical education. Responsibility for the approval of the training provided in the Foundation Programme rests with the General Medical Council (GMC) as the regulator. The Foundation Programme is regulated by the GMC, through its Postgraduate Board. The regulator has in place a robust quality assurance system which is set out in the *Quality Improvement Framework* (QIF). Through the QIF, the GMC:

- approves deaneries responsible for foundation training; LEPs delivering foundation training; the foundation curriculum assessment system and foundation programmes
- maintains an evidence base of information from deaneries about foundation training, gathered through scheduled reports from deaneries every six months
- carries out visits to quality assure foundation training as part of regional visits to deaneries
- supports the development and improvement of local Foundation Programme education and training by ensuring that useful and innovative educational practices are shared (horizontal connections)
- ensures that foundation training is aligned with undergraduate and postgraduate education (vertical connections).

### i) Quality assurance – carried out by the regulatory authorities

Quality assurance encompasses all the policies, standards, systems and processes involved with ensuring maintenance and enhancement of the quality of postgraduate medical education in the UK. The regulator undertakes planned and systematic activities to provide public and patient confidence that postgraduate medical education satisfies given requirements for quality within the principles of good regulation.

### ii) Quality management – carried out by the postgraduate deanery

Quality management refers to the arrangements by which the postgraduate deanery discharges its responsibility for the standards and quality of postgraduate medical education. The deanery must satisfy itself that local education and training providers are meeting the regulator's standards through robust reporting and monitoring mechanisms.

### iii) Quality control – carried out at local education provider (LEP) level

Quality control relates to the arrangements (procedures and organisation) within local education providers (health boards, NHS trusts and independent sector organisations) that ensure foundation doctors receive education and training that meet local, national and professional standards.

These processes are interdependent. The regulator's quality assurance is a systematic educational audit of the deanery quality management systems; the latter must include review of LEP quality control measures. The regulator has set national standards for the delivery and outcomes of the Foundation Programme and deaneries are required to demonstrate through reports and visits that the standards have been met.

There are nine domains of activity described:

- Patient safety
- Quality assurance, review and evaluation
- Equality, diversity and opportunity
- Recruitment, selection and appointment

# Appendix C

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- Delivery of the Curriculum including assessment
- Support and development of foundation doctors, trainers and local faculty
- Management of education and training
- Educational resources and capacity
- Outcomes.

In each domain, the regulator has described who is responsible for its achievement, the standard(s) to be reached, and the criteria by which its achievement is judged. The standards set by the regulator are mandatory, but the processes by which deaneries quality manage, and LEP quality control, the programme provision are not specified.

Full information on the quality assurance of the Foundation Programme can be obtained from the GMC website at [www.gmc-org.uk](http://www.gmc-org.uk).

Examples of 'good practice' in the implementation of the Curriculum can be found on the UKFPO website at [www.foundationprogramme.nhs.uk](http://www.foundationprogramme.nhs.uk).



# Appendix D

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## Curriculum design and educational framework

### Educational principle underlying curriculum design

Doctors should never stop learning. At every stage in their careers they should continue their professional development, refine their clinical skills and techniques and the quality of their interactions with others. Doctors must understand their strengths and weaknesses, their personal style, assumptions and beliefs. This requires doctors to be open to feedback and, with reflection and guidance, to be able to modify their behaviours.

The developmental process involves recognition that at the start of their professional career doctors have to work through an explicit set of processes before being able to formulate a hypothesis which leads to a differential diagnosis. They may then use protocols and guidelines to decide on relevant investigations and management. They will understand that an expert clinician may reach a similar diagnosis and appear to have made an intuitive leap with relatively limited information. However, this will have been based on widespread knowledge and extensive experience. It may take account of the knowledge that 'common things commonly occur', but also that rare events are possible and can be suspected when there is something unusual in a patient's presentation.

### Curriculum design

The *Foundation Programme Curriculum* is designed to imbue and foster the ethos of continual learning aided by reflection which will serve doctors throughout their careers.

Foundation doctors are developing professionals and need to deepen and broaden their understanding and expertise. This means:

- recognising that expertise increases throughout their careers and should be based on using experience and reflection to drive learning
- revisiting clinical and professional practice, and studying in increasing depth
- practising at increasingly complex levels with decreasing supervision
- taking increasing responsibility for the supervision and organisation of others.

These attributes are recognised throughout the Curriculum which seeks to provide opportunities for development through practice and engagement with learning in the workplace. Supervised learning events encourage the recognition of good practice and also allow targets for development to be identified and worked on.

Foundation year 1 (F1) and foundation year 2 (F2) outcome descriptors are provided throughout the Curriculum, these describe the increasingly sophisticated performance expected from foundation doctors across the competences as they progress through the programme. Foundation doctors and trainers should use these to help direct developmental targets.

### Educational framework

The Dreyfus model of skills acquisition (Table 9) describes different levels and aspects of practice in the spiral curriculum (Figure 2) from medical school to specialist training.

# Appendix D

Table 9. Summary of the Dreyfus model of skills acquisition

<p><b>Level 1: Novice</b></p> <ul style="list-style-type: none"><li>• Rigid adherence to taught rules or plans</li><li>• Little situational perception</li><li>• No discretionary judgement</li></ul> <p><b>Level 2: Advanced beginner</b></p> <ul style="list-style-type: none"><li>• Guidelines for action based on attributes or aspects (global characteristics of situations recognisable only after some prior experience)</li><li>• Situational perception still limited</li><li>• All attributes and aspects are treated separately and given equal importance</li></ul> <p><b>Level 3: Competent</b></p> <ul style="list-style-type: none"><li>• Coping with crowdedness</li><li>• Now sees actions at least partly in terms of longer term goals</li><li>• Conscious deliberate planning</li><li>• Standardised and routine procedures</li></ul> <p><b>Level 4: Proficient</b></p> <ul style="list-style-type: none"><li>• Sees situations holistically rather than in terms of individual aspects (see above)</li><li>• Sees what is most important in a situation</li><li>• Perceives deviations from the normal pattern</li><li>• Decision-making less laboured</li><li>• Uses maxims (whose meaning varies according to the situation) for guidance</li></ul> <p><b>Level 5: Expert</b></p> <ul style="list-style-type: none"><li>• No longer predominantly reliant on rules, guidelines or maxims</li><li>• Intuitive grasp of situations based on deep tacit understanding</li><li>• Analytic approaches used only in novel situation or when problems occur</li><li>• Vision of what is possible</li></ul>
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Source: *Eraut, M. Developing Professional Knowledge and Competence (1994)*

Understanding the five Dreyfus levels will enable foundation doctors to manage each stage of a patient's journey more effectively. They will steadily build up their expertise from having specific skills to managing the whole patient experience. They will gradually need less supervision.

Such models will also help supervisors and assessors expand what they look for in the foundation doctor's work and therefore make better judgements on their progress. In addition to using the F1 and F2 outcome descriptors a supervisor/assessor might consider/ask:

- is the foundation doctor using a more discerning mix of clinical understanding, protocols and guidelines?
- is the foundation doctor carrying out procedures and making decisions more quickly?
- can other team members describe how the foundation doctor has gained confidence in their decisions and their risk assessments?
- are there fewer complaints from patients?
- does the foundation doctor ask for help less often?

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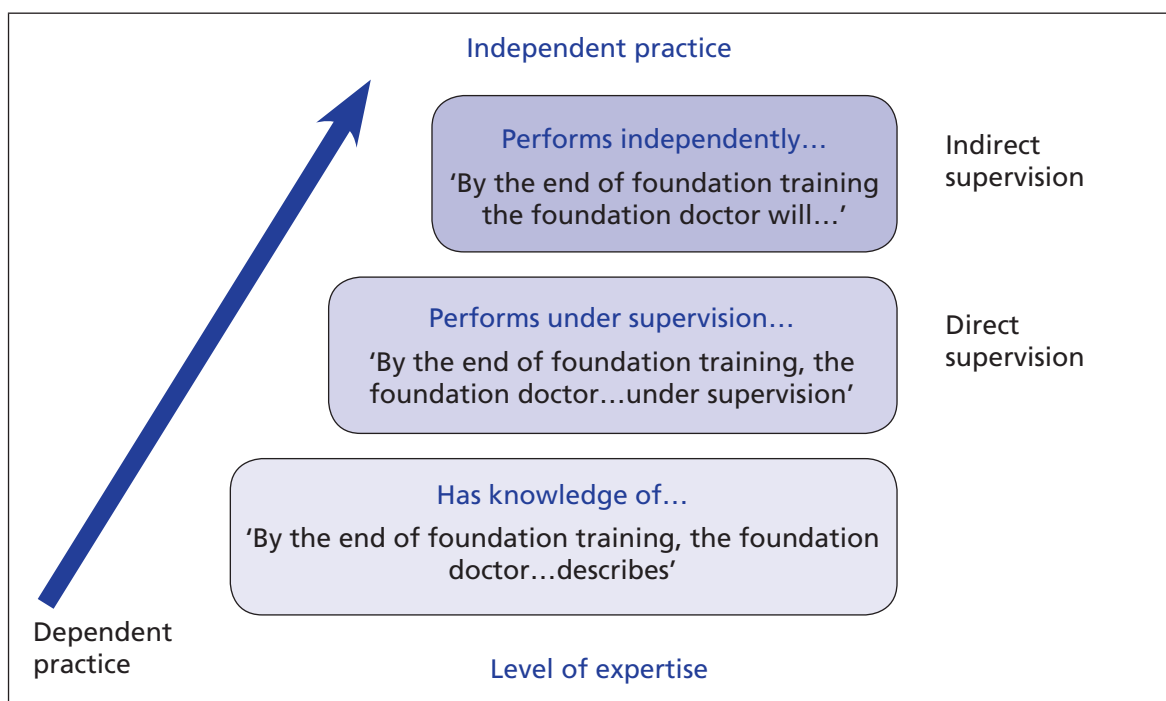
# Appendix D

The following two examples illustrate how this can be applied in intensive care and inserting a chest drain.

## Intensive care model

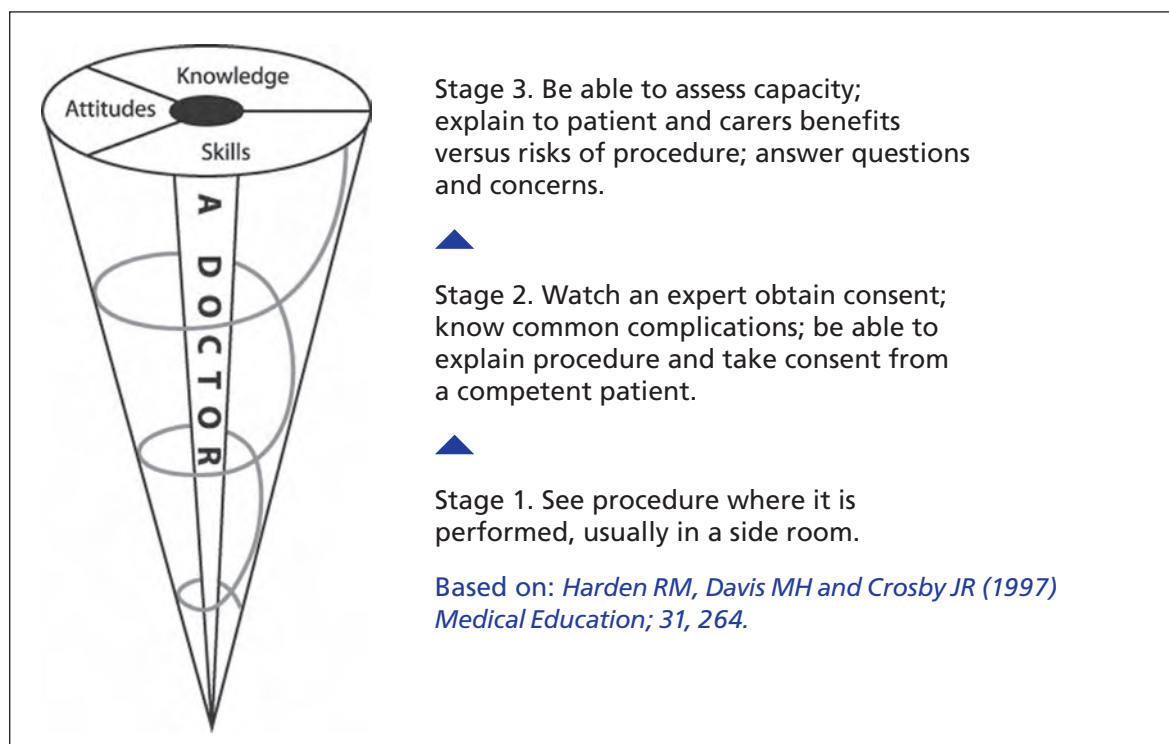
A modification of the intensive care competence development framework is shown below (Figure 1). It illustrates the improvement of clinical practice and different levels of supervision in different aspects of the Foundation Programme. Understanding this progression will enable foundation doctors to assess and reflect upon their clinical management more accurately.

Figure 1. Development of core competences for the Foundation Programme independent practice



# Appendix D

Figure 2. Example of the spiral curriculum  
Consent for inserting a chest drain



## Educational culture and practice

All doctors are responsible for their own education, however, they must understand the needs of patients and how to contribute to the safe practice of medicine within the organisation where they work. At the same time doctors must appreciate that learning in the workplace through supervised service delivery requires them to manage their learning needs in the context of their clinical work. They should understand the complexities, constraints and opportunities that they find in their practice and be able to choose how to make best use of these. Doctors also need to understand that, as well as engaging in more formal educational activities, they learn by working with other team members and seeking out feedback from senior colleagues in supervised learning events (SLEs).

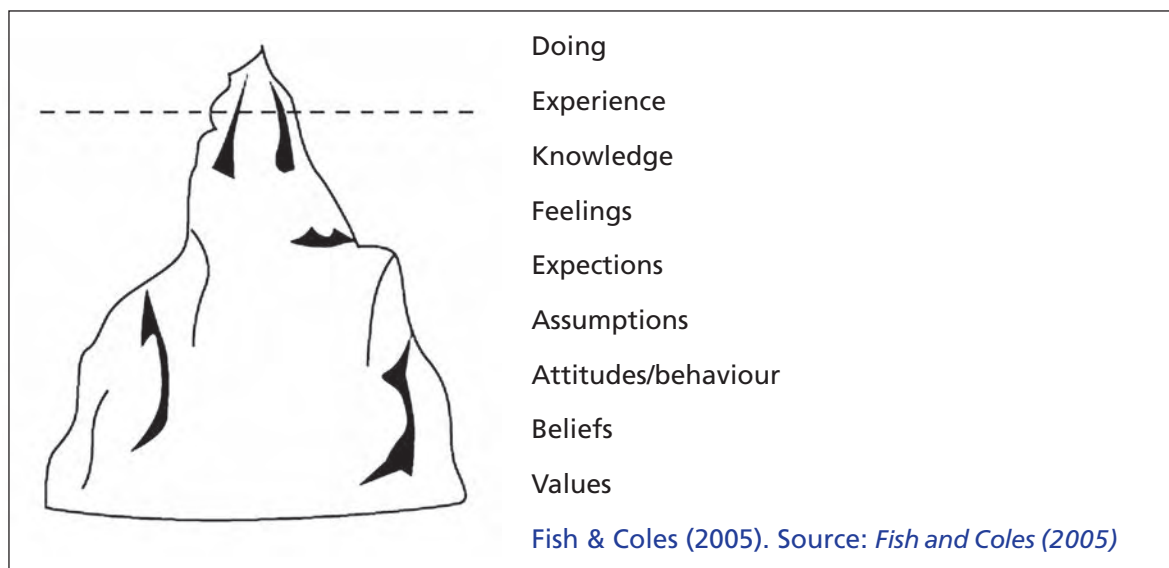
Good educational practice acknowledges the private and public aspects of professional development and gives due importance to the key relationships which inform professional development. Effective learners will achieve their aims, acknowledging that who they are and what they believe affects what they do. Foundation doctors do not live in a vacuum; they may have personal and family difficulties and the most effective learners recognise the impact of these factors and develop as a result of them.

Effective educational practice will help foundation doctors understand the relationship between theory and reality, which will enable them to exercise better judgement in complex situations. They will also be encouraged to understand other roles within the team and show how they can adapt and collaborate in emergency situations. They will need to become aware of the different perspectives and expertise that can improve problem solving, clinical reasoning, patient management and decision making. This depth of understanding and expertise requires study and practice of all the components of professional activity, as outlined in the metaphor of the iceberg (Figure 3).

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# Appendix D

Figure 3. Developing a curriculum for practice



Acquiring expertise that can be adapted to new situations depends on the development of clinical and ethical reasoning and professional judgement. Much learning occurs in teams and much knowledge and expertise is found in groups rather than in individuals. This strengthens the principle that learning in the Foundation Programme should take place in team-based practice. Expertise is more than knowledge or a tool kit of skills. The foundation doctor will learn similar skills in different settings, facilitating the development of transferable skills.

Doctors at the start of their careers seek predictable solutions rather than acknowledging the paradoxes and ambiguities of clinical practice. The following actions should be considered:

- exploring new courses of action
- reflecting on what happens
- accepting unpredictability.

Similarly, the acquisition and application of skills and knowledge will vary according to where care is given. General practice will enable foundation doctors to care for acutely ill patients in a different setting from secondary care. Patients will present differently and their illnesses will be seen at a much earlier stage. Their management will need different clinical and risk assessment skills. Also, primary care offers a unique perspective on how secondary care specialties work. Foundation doctors will be able to follow their patients through the service, from the presentation of acute illness through investigation, diagnosis and management to recovery, rehabilitation or death. They will also be able to see the effect of acute illness on those with a long-term disease.

Consideration will need to be given as to whether the clinical context for learning needs to be more closely prescribed to ensure that foundation doctors acquire generic competences across a range of clinical situations. For example, meaningful competences in child health can be acquired outside paediatric (or general practice) placements.

# Appendix E Mapping the Foundation Programme Curriculum 2012 to GMC standards

The *Foundation Programme Curriculum* has been mapped to the four domains of the General Medical Council, illustrating where the standards have been fulfilled in the Curriculum syllabus.

## Domain 1 – Knowledge, Skills and Performance

Attributes	Generic Standards	FP Curriculum Syllabus Reference
Maintain your professional performance	• Maintain knowledge of the law and other regulation relevant to your work	4.1, 4.2, 4.3
	• Keep knowledge and skills up to date	6.1
	• Participate in professional development and educational activities	6.1
	• Take part in and respond constructively to the outcome of systematic quality improvement activities (e.g. audit), appraisals and performance reviews	3.2 Learning & teaching Appendix D (Figure 2)
Apply knowledge and experience to practice	• Recognise and work within the limits of your competence	1.1
	• If you work in research, follow appropriate national research governance guidelines	6.2
	• If you are a teacher/trainer, apply the skills, attitudes and practice of a competent teacher/trainer	5
	• If you are a manager, work effectively as a manager	1.4, 1.5
	• Support patients in caring for themselves	10.2 - 10.5
	• If you are in a clinical role <ul style="list-style-type: none"> <li>o Adequately assess the patient's conditions</li> <li>o Provide or arrange advice, investigations or treatment where necessary</li> <li>o Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately</li> <li>o Provide effective treatments based on the best available evidence</li> <li>o Take steps to alleviate pain and distress whether or not a cure may be possible</li> <li>o Consult colleagues, or refer patients to colleagues, when this is in the patient's best interests</li> </ul>	7.2, 7.3, 8.1 7.3, 7.4, 7.5, 7.6, 8.2, 8.3, 8.5, 8.7, 9.1, 10.4, 11 7.5 3.2, 6.2, 7.5 7.5, 8.4 1.3, 7.1, 7.9, 10.3, 11
	Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible	• Make records at the same time as the events you are recording or as soon as possible afterwards
• Ensure that any documentation that records your findings, decisions, information given to patients, drugs prescribed and other information or treatment is up to date and accurate		1.3, 2, 7.5, 7.8

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# Appendix E Mapping the Foundation Programme Curriculum 2012 to GMC standards

## Domain 2 – Safety and Quality

Attributes	Generic Standards	FP Curriculum Syllabus Reference
Contribute to and comply with systems to protect patients	• Take part in systems of quality assurance and quality improvement	3.2, 5, 6.1, 6.2 Appendix C, Appendix D (Figure 2)
	• Comply with risk management and clinical governance procedures	3.2, 6.1, 6.2, 7.1
	• Co-operate with legitimate requests for information from organisations monitoring public health	4.1, 4.2
	• Provide information for confidential enquiries, significant event reporting	3.2, 6.1, 7.1
	• Make sure that all staff for whose performance you are responsible, including locums and students, are properly supervised	Purpose of the FP, 1.1 – 1.4, 2, 6, 7.2, 7.3, 7.5
	• Report suspected adverse reactions	7.5, 7.6
	• Ensure arrangements are made for the continuing care of the patient where necessary	1.3, 7.5, 10.2
	• Ensure systems are in place for colleagues to raise concerns about risks to patients	3.2, 6, 7.1, 7.3
Respond to risks to safety	• Report risks in the healthcare environment to your employing or contracting bodies	3.1, 3.2, 7.1
	• Safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with learning disabilities	1.4, 2, 4.2, 7.1, 7.2
	• Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk	3.1, 3.2, 7.1
	• Respond promptly to risks posed by patients	7.1, 7.7, 8.7
	• Follow infection control procedures and regulations	7.7
Protect patients and colleagues from any risk posed by your health	• Make arrangements for accessing independent medical advice when necessary	2.1, 8.2, 8.3
	• Be immunised against common serious communicable diseases where vaccines are available	3.1, 7.7

# Appendix E Mapping the Foundation Programme Curriculum 2012 to GMC standards

## Domain 3 – Communication, Partnership and Teamwork

Attributes	Generic Standards	FP Curriculum Syllabus Reference
Communicate effectively	• Listens to patients and respects their views about their health	1.1, 2.1, 2.2, 7.2, 7.3, 9.2, 10.1 – 10.5
	• Give patients the information they need in order to make decisions about their care in a way they can understand	2.1 – 2.3, 10
	• Respond to patients' questions	2.1 – 2.3, 10
	• Keep patients informed about the progress of their care	2.1 - 2.3, 10.1, 10.2, 10.4
	• Explain to patients when something goes wrong	2.2 - 2.4
	• Treat those close to the patient considerately	1.1, 2.1-5
	• Communicate effectively with colleagues within and outside the team	1.1, 1.4, 7.9
	• Encourage colleagues to contribute to discussions and to communicate effectively with each other	1.1, 1.3, 1.4, 6.1, 7.1, 7.9
Work constructively with colleagues and delegate effectively	• Pass on information to colleagues involved in, or taking over, your patients' care	1.2 - 1.4, 7.9, 11
	• Treat colleagues fairly and with respect	1.1, 1.4, 5, 7.9
	• Support colleagues who have problems with their performance, conduct or health	1.1, 1.4, 3.1, 3.2, 7.1, 7.9
	• Act as a positive role model for colleagues	1.1, 1.5
	• Ensure colleagues to whom you delegate have appropriate qualifications, experience	1.2, 7.1
Establish and maintain partnerships with patients	• Provide effective leadership as appropriate to their role	1.1 – 1.51, 4, 5, 6, 7.2, 7.3, 7.5, 7.7, 9.1, 10.1, 11
	• Encourage patients to take an interest in their health and take action to improve and maintain it	2.1, 2.2, 2.3, 7.3, 10
	• Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research	2.5, 7.2, 7.5, 7.8, 11, 12



# Appendix E Mapping the Foundation Programme Curriculum 2012 to GMC standards

## Domain 4 – Maintaining Trust

Attributes	Generic Standards	FP Curriculum Syllabus Reference
Show respect for patients	• Implement and comply with systems to protect patient confidentiality	4.1
	• Be polite, considerate and honest and respect patients' dignity and privacy	1.1, 1.4, 2.1, 2.2, 2.4, 4.1, 7.5
	• Treat each patient fairly and as an individual	1.1, 2, 7.1
	• If you undertake research, respect the rights of patients participating in the research	2.1, 6.2
Treat patients and colleagues fairly and without discrimination	• Be honest and objective when appraising or assessing colleagues and when writing references	1.1, 2.1
	• Respond promptly and fully to complaints	1.2, 2.6
	• Provide care on the basis of the patient's needs and the likely effect of treatment	2.1, 7.1, 7.3, 7.5, 9.2, 10.1, 10.3, 10.4, 11
Act with honesty and integrity	• Ensure you have adequate indemnity or insurance cover for your practice	Syllabus in practice
	• Be honest in financial and commercial dealings	1.1
	• Ensure any published information about your services is factual and verifiable	n/a
	• Be honest in any formal statement or report, whether written or oral, making clear the limits of your knowledge or competence	Syllabus in practice 1.1
	• Inform patients about any fees and charges before starting treatment	n/a
	• If you undertake research, obtain appropriate ethical approval and honestly report results	6.2

# Appendix F

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## Curriculum development and list of contributors

It was stated in the *Foundation Programme Curriculum* (AoMRC, 2010) that a revision would take place in 2014 for use in 2015. Further to the *Foundation for Excellence: An Evaluation of the Foundation Programme* report (MEE, 2010) and *The Trainee Doctor* (GMC, 2011) this revision has taken place for use from August 2012.

A wide consultation of stakeholders was undertaken. Further advice was sought on the content and layout of various drafts of the *Foundation Programme Curriculum*. Undergraduate and postgraduate trainers, as well as organisers of training, foundation doctors, other trainee doctors and patient groups, were included in these consultations. The opinion of foundation doctors was sought from the Academy Trainee Doctors' Group, the British Medical Association Junior Doctors Executive Committee, the BMA Medical Students Committee and the UKFPO Foundation Doctors' Board. The opinion of patients was sought from the AoMRC Patient/Lay Group and National Voices.

Under the AoMRC Foundation Programme Committee's (AFPC) supervision the main work of revising the Curriculum was undertaken by two working groups:

### Assessment in foundation

Dr Ed Neville (Chair)

Professor Paul Baker, Foundation School Director; Professor Jonathan Beard, Royal College of Surgeons of England; Ms Lesley Briggs, AoMRC Patient/Lay Group; Dr Stuart Carney, Deputy National Director, UKFPO; Dr Alan Connacher, AFPC/RCPE; Ms Manjula Das, AoMRC; Dr David Kessel, AoMRC Foundation Programme Committee/Royal College of Radiologists; Dr Barry Lewis, COGPeD; Dr Jane Mamelock, COGPeD; Dr Noah Moran, Foundation Doctor; Professor Paul O'Neill, Medical Schools Council; Dr Sangeetha Rajoo, Foundation Doctor; Ms Susan Redward, General Medical Council; Dr Alasdair Strachan, Foundation School Director; Ms Winnie Wade, RCPL/Educationalist and Dr Andrew Whitehouse, Foundation School Director.

### Syllabus

Dr David Kessel (Chair)

Dr Sripurna Basu, Foundation Doctor; Dr Stuart Carney, UKFPO, Dr Alan Connacher, AFPC/RCPE; Dr Helen Cugnoni, College of Emergency Medicine; Ms Manjula Das, AoMRC; Dr Paul Dilworth, Medical Schools Council; Dr Emily Han Shao, Foundation Doctor; Dr Namita Kumar, Foundation School Director; Dr Barry Lewis, COGPeD; Dr Albert Lim, Foundation Doctor; Dr John Lowe, Royal College of Psychiatrists/AoMRC Foundation Programme Committee; Ms Susan Redward, General Medical Council; Dr Paul Sadler, Foundation School Director; Dr Helen Smith, Foundation School Director and Dr Emma Young, College of Emergency Medicine.

Based on the recommendations of the working groups, the AFPC assembled the draft *Foundation Programme Curriculum* (the Curriculum) which was sent for stakeholder review in 2011. After assimilation of these comments the revised draft was agreed by the AFPC and thereafter sent to the regulators for approval.

# Appendix F

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The following individuals contributed to the current *Foundation Programme Curriculum*:

Dr David Kessel, Chair of the AoMRC Foundation Programme Committee

Members of AoMRC Foundation Programme Committee:

Professor Dinesh Bhugra, PRCPsych/Education Lead AoMRC; Dr Stuart Carney, UKFPO; Dr Angela Carragher, NIMDTA; Dr Alan Connacher, RCPE; Dr Helen Cugnoni, College of Emergency Medicine; Ms Manjula Das, Academy of Medical Royal Colleges; Dr Mandy Goldstein, RCPCH; Dr Jonathan Goodall, FICM; Mr Alastair Henderson, Academy of Medical Royal Colleges; Dr Andrew Jeffrey, NACT UK; Dr Barry Lewis, COGPed; Dr John Lowe, Royal College of Psychiatrists; Dr Matthew Mak, Foundation Doctor; Professor Gus McGrouther, RCSEng; Mr Sol Mead, AoMRC Patient/Lay Group; Dr Fiona Moss, COPMed; Professor Philip Murray, Royal College of Ophthalmologists; Dr Brian Neilly, RCPSG; Dr Ed Neville, AoMRC Foundation Assessment Lead; Ms Susan Redward, GMC; Dr Brian Shine, RCPATH; Dr Anthony Starczewski, Associate Dean for SHOs Wales; Dr Andrew Todd, RCPSG; Ms Winnie Wade, RCPL/Educationalist; Dr Premila Webster, Faculty of Public Health and Dr Melissa Whitten, RCOG.

We are extremely grateful to Ms Manjula Das of the Academy of Medical Royal Colleges who supported the AFPC, its working groups and co-ordinated and managed the technical development of the Curriculum.

Repeated advice was sought on the content and layout of various drafts of the Curriculum.

Undergraduate and postgraduate trainers, as well as organisers of training, were included in these consultations. The opinion of foundation doctors was sought from the Academy Trainee Doctors' Group, the British Medical Association Junior Doctors Executive Committee, the BMA Medical Students Committee and the UKFPO Foundation Doctors' Board. A stakeholder review took place prior to this iteration of the Curriculum.

The Academy of Medical Royal Colleges Foundation Programme Committee will continue to review and evaluate the Curriculum. A further rewrite is scheduled to take place in 2014, to be in place by August 2015. Evaluation of the Curriculum will be included in each deanery's quality management process and the QAFP mechanism will monitor this.

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