

letters to the editor

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Now I know what I don't know: how to reform the foundation years to fit 21st-century medicine

Editor – Laura Watts makes some good points in her critique of the UK Foundation Programme (*Clin Med* April 2013 pp163–5). Her proposal that there should be more flexibility in the choice of placements in the second year, to allow better preparation for subsequent specialty applications, is already in place in the West Midlands, where all foundation year (FY) doctors select their second year programme during March of their FY1 year and compete for popular rotations through evidence of their engagement in the programme with their ePortfolios.¹ In 2012 and 2013, all 570 FY1 doctors in the West Midlands deanery responded to a survey on the principal and the process of this system. Two-thirds consistently state that they prefer this uncoupled 2-year programme to a fixed 2-year programme.

The shortcomings Watts describes of the original assessment system in the Foundation Programme are well documented in the literature and have actually already been addressed in the 2012 curriculum.² While it is true that the workplace assessments formerly used as 'evidence of competence' have been renamed as supervised learning events (SLEs), more importantly their function has also been completely changed. They are now only used formatively for teaching and the 'results' of SLEs are disregarded in judging a trainee's suitability to progress. The trainees must still engage in SLEs, using them to seek teaching on their weaker topics, but progression is now judged by reviews of their workplace clinical performance. Performance is what they actually do and is different from competence (what they *can* do), and reflects much more accurately how skilled they are clinically than the much derided 'assessment of competence' using miniCEX and CbD.

True performance assessment of interpersonal and communication skill, professionalism and teamworking using the multi source feedback TAB, has long been the most valued assessment tool in the Foundation Programme. From August 2012, trainees' overall clinical performance is also assessed in each foundation placement by the placement supervision group (PSG), which pools views from qualified observers, including consultants, senior specialty trainees and specialist nurses, to add weight to the clinical supervisor's end of placement report. This group review is like the 'local faculty group' model, increasingly popular as a clinical assessment process in specialty programmes, and which also relies on true performance assessment by multiple consultants.

Specialty curriculum redesign, including core medical training (CMT), followed on from foundation training in 2007, adopting the tools of workplace assessment which were initially used in foundation programmes. We may well see improved methods of clinical assessment, as now specified for foundation year doctors coming in to CMT and other medical specialty curricula before long, addressing a widespread unease about the unreliability and bureaucratic burden of the competence assessment tools we are still required to use in CMT.

ANDREW WHITEHOUSE

*Head of foundation training and Head of
Postgraduate School of Medicine,
Health Education West Midlands*

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- 1 Palmer R, Howes J, Whitehouse A. Using assessment to drive learning by linkage to Foundation year 2 allocation process. *BJ Hosp Med* 2008;69:472–3.

- 2 The Foundation Programme. Key documents, 2013. www.foundationprogramme.nhs.uk/pages/home/keydocs [Accessed 4 June 2013].

Now I know what I don't know: how to reform the foundation years to fit 21st-century medicine

Editor – Dr Watts (*Clin Med* April 2013 pp163–5) portrays the success of the four nations Foundation Programme Curriculum (FPC) – providing a curriculum for the first 2 years of postgraduate practice where none previously existed, thus addressing the muddle facing senior house officers (SHOs) of the 'lost tribe'.

She graphically illustrates the problems facing young doctors resulting from the European working time directive (EWTd) with the resultant loss of the 'firm' system of support from seniors that they knew and with whom they shared mutual trust. If Dr Watts is 'expected to cope single handedly with 80–100 patients out of hours' this is totally contrary to the principles of FPC and a matter for urgent attention by the local education provider or Deanery Quality Management process.

Dr Watts' concerns echo those in the Foundation for Excellence¹ report relating to delivery and over-assessment rather than the curriculum itself.

The 2012 FPC revision has addressed some of those concerns, in particular:

- 1 FPC consists outcome-based, high-level descriptors that indicate the expected performance at foundation year (FY) 1 and 2 level. There is no need to try to acquire evidence for every competence.
- 2 Assessment is based largely on observations of the FY doctor's performance in the workplace.
- 3 Supervised learning events (SLEs) have replaced workplace-based assessments.³ SLEs exist purely to deliver feedback to help the trainee develop and provide material for reflection. SLEs do not form part of the assessment process.

There has been, and always will be, some dissatisfaction with allocation of rotations, but many deaneries (including Dr Watts' own)⁴ offer opportunities to swap. Previously, many doctors had to seek a new job every 6–12 months. The primary requirement for

placements and rotations is that trainees are able to demonstrate delivery of the educational objectives set out within the FPC.

The FPC is broad and generic. Following the Foundation Programme, trainees uncertain of their career direction can choose broad-based programmes⁵ and unthemed core training programmes in medicine⁶ and surgery.⁷

DAVID KESSEL

Chair, Foundation Programme Committee,¹
honorary clinical associate professor²

ED NEVILLE

Foundation assessment lead¹

¹Academy of Medical Royal Colleges;

²Leeds University Medical School, Leeds, UK

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Endocrine disease in pregnancy

Editor – I read with interest the excellent update on endocrine disease in pregnancy

Table 1. Herbal medicines causing serious adverse drug reactions.

Herbal medicine causing serious ADRs	Common names	Common uses
<i>Larrea tridentate</i>	Creosote	Cancer, acne, rheumatism, diabetes
<i>Herbae pulvis standardisatus</i>	Atropa belladonna, belladonna herbum, deadly nightshade	Menstrual symptoms, peptic ulcer disease, motion sickness
<i>Piper methysticum</i>	Kava kava	Anxiolytic
<i>Cassia senna</i>	Sena	Laxative

ADR = adverse drug reaction.

(*Clin Med* April 2013 pp179–81). I write to draw your attention to an often neglected pituitary emergency: pituitary apoplexy.

Pituitary apoplexy is a potentially life threatening medical emergency. Pregnancy is mentioned by Frise and Williamson as a possible cause of pituitary insufficiency. However, pregnancy and the immediate post-pregnancy period is a predisposing factor for pituitary apoplexy as a pre-existing pituitary adenoma may haemorrhage or infarct (eg, postpartum Sheehan's syndrome).

This could then lead to acute pituitary insufficiency requiring immediate recognition of this presentation and urgent replacement with hydrocortisone and other pituitary hormones. Patients often present with headaches, vomiting, hypotension and can suffer with visual loss or ophthalmoplegia. It is recommended that patients are urgently referred to a joint pituitary (endocrine & neurosurgery) team.

I would be grateful if you could draw your readers attention to the national guidelines on pituitary apoplexy.¹

STEPHANIE E BALDEWEG

Consultant physician in diabetes and endocrinology, and honorary senior lecturer

Department of Diabetes & Endocrinology,
University College London Hospitals NHS
Foundation Trust, London UK

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- Rajasekaran S, Vanderpump M, Baldeweg S *et al*. UK guidelines for the management of pituitary apoplexy. *Clin Endocrinol (Oxf)* 2011; 74:9–20.

Adverse effects of herbal medicine

Editor – We write with reference to the manuscript 'Adverse effects of herbal medicine: an overview of systematic reviews' by Posadzki *et al* (*Clin Med* February 2013 pp 7–12), which reviews the severity of the adverse effects of herbal drugs.

It was gratifying to note that very few of the drugs, such as *Cassia senna*, *Camellia sinensis*, *Commiphora mukul* and *Stevia rebaudiana*, which have serious or moderately severe side effects, are being used and prescribed by indigenous practitioners in India (Table 1). However, other herbal remedies, such as *Lavandula angustifolia miller*, *Ginkgo biloba*, *Trigonella foenum-graecum*, *Gymnema sylvestre*, *Panax ginseng*, *Silybum marianum* and *Cinnamomum* spp, which have mild side effects, are also commonly used by Indian practitioners. This is a point for caution.

In addition, possible herb-drug interactions have also been reported which are associated with increased risk of adverse drug reactions (ADRs), probably due to the induction or inhibition of cytochrome P450 isoenzymes. For example, *Ginkgo* (*Ginkgo biloba*) can cause spontaneous bleeding when combined with warfarin, and coma when combined with trazodone. *Ginseng* (*Panax ginseng*) lowers concentrations of warfarin (and alcohol), and induces mania and insomnia if used concurrently with phenelzine.¹

More studies are needed to clarify and determine the clinical importance of herb-drug interactions. It is imperative for health professionals, patients, regulatory authorities and suppliers of herbal medicines to be cognisant of the possible ADRs and drug interactions caused when herbal medicines