A Personal Critical Analysis of the Foundation Programme Curriculum [version 1]

Hassaan Waqar

St Helens and Knowsley Teaching Hospitals NHS Trust – Lead Employer

Abstract

This article was migrated. The article was marked as recommended.

The Foundation Programme (FP) is a two-year period where medical graduates are able to learn in the workplace in the United Kingdom. The Foundation Programme Curriculum (FPC) is designed to imbue trainees with the knowledge, skills and attitudes to be able to enter into speciality training. The reasons for the introduction of the FP and its curriculum will be discussed. Additionally, curricular aims and models pertaining to the curriculum of the FP will be discussed as will the relevance of the hidden curriculum to the FPC. The assessment strategies and quality assurance methods relating to the FPC will be also be discussed. The author has been a recent FP trainee and uses education theory in his assessment of its curriculum. In this personal critical analysis, I aim to review the curriculum of the FP in order to determine if it is an appropriate vehicle to transmit the necessary knowledge, skills and attributes for trainees to enter the next stage of their training.

Keywords

Foundation Programme, Foundation Programme Curriculum, Curriculum Models, Curriculum Aims, Assessment, Quality Assurance

Corresponding author: Hassaan Waqar (hassaan.waqar@doctors.org.uk)
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Introduction

A curriculum was defined by R.M. Harden as:

"...more than just a syllabus or a statement of content. A curriculum is about what should happen in a teaching programme - about the intention of teachers and the way they make this happen" (Dent and Harden, 2009).

The FP is a two-year period where medical graduates are able to learn in the workplace in the United Kingdom. This entails application of the knowledge that they have gained at medical school in order to develop their clinical and professional capabilities as a doctor. The FP enables those who successfully complete it to go on to further training. The FPC is designed to imbue trainees with the knowledge, skills and attitudes to be able to enter into this next phase of their training. The FPC was designed in response to legislative change and applies educational theory in order to deliver an effective curriculum. The FPC is regulated in part by stakeholders in order to match the high expectation that the public have of all doctors. Assessment tools are used to ensure that trainees have met the minimum level of competence in multiple faculties in order to progress to the next stage of their training. Curricula are designed to meet particular aims and there are various models of curriculum design which can be used to achieve these objectives. There are various quality assurance processes involved in maintaining and refining a curriculum in order to ensure its effectiveness in light of changes to practice. I aim to explore the above themes and concepts and relevant educational, social and political influences on the FPC. This is in order to determine if the FPC is an appropriate vehicle to transmit the necessary knowledge, skills and attitudes for trainees to enter the next stage of their training.

Why were the FP and the FPC introduced?

Prior to the introduction of the FP, postgraduate medical training suffered from flaws such as poorly planned training, insufficient supervision and assessment. In addition, training was thought to be inflexible and suffered from poor job structure, with unstandardised appointment procedures which were non competency dependant. In response to this, the Department of Health commissioned a review by the Chief Medical Officer (CMO) in 2002 that highlighted the above concerns and recommended a restructuring of postgraduate medical training by focusing on the Senior House Officer (SHO) grade. The SHO grade, at the time, was all doctors who had completed at least one year of training after graduation, known as the Pre-registration House Officer grade (PRHO), but who had not yet progressed to a Speciality Registrar position (Donaldson, 2002).

The consultation document recommended the creation of a two-year FP which would include the PRHO grade and enable doctors to gain core skills early on in their first two years after graduation from medical school. It also encouraged the creation of a curriculum based programme to address the unstructured SHO training pathway that existed at the time. The consultation document does not appear to have been well received by the doctors and was followed up by Department of Health policy which outlined the two-year programme consisting of rotations in various clinical specialities, at the end of which trainees would be eligible to enter speciality training. The first year of the programme, known as Foundation Year One (FY1) was similar to the existing PRHO grade, after which trainees gained full registration with the General Medical Council (GMC). The SHO grade was split into Foundation Year Two (FY2) grade and various Core Training (CT) and Speciality Training (ST) grades (Department of Health, 2004). This policy document required the establishment of a curriculum for the FP in order to determine if trainees had met a pre-defined number of competencies. The FPC was established based upon specific principles, such as defining the competencies being assessed and the method of their assessment. The first iteration of the FPC (The Foundation Programme Committee, 2005) was produced with the assistance of the Department of Health lead by the same CMO who wrote the consultation document mentioned earlier. Whilst it is unclear the extent to which the FPC was politicised, given the CMO having direct input into its first iteration, it appears that some of the changes may have been politically driven following the CMO’s initial consultation document.

Additionally, the FP itself was set up to meet the legal requirements of the GMC and had to adapt to fit with the European Working Time Directive (EWTD) which limited the number of hours a doctor could work in an average week as reported in the literature by The Lancet (2005). The EWTD had a profound impact on the working lives of Foundation Year trainees as it affected rostering of junior doctors. The 48 average working week as legislated by the EWTD was analysed by Goddard, Hodgson and Newbery (2010) who found that, possibly as an indirect result of this legislation, Foundation Year doctors were the most senior doctor on call at night in certain hospitals. This appears to be contrary to one the reasons
that the FP and by extension its curriculum was introduced, which was to ensure adequate supervision of trainees. This highlights that whilst the FPC may have been designed to be an ideal curriculum, its delivery has to some degree been hampered by wide ranging political changes.

Curriculum models

The FP could be thought of as a spiral curriculum as described by Harden, Davis and Crosby (1997). In this curriculum model, new content is linked to prior learning and previously learnt topics are revisited in order to reinforce prior learning. The FPC divides expected learning into two years, however competencies are revisited and those gained in the second year build upon those acquired in FY1. Additionally, this model has accounts for certain content being more challenging than others and that the competence of students increases. The FPC encourages FY2 trainees to take on more responsibility in managing patients’ medical problems, possibly as they now have full GMC registration and they have more experience, and so are able to make more senior decisions compared to a FY1 junior doctor.

Harden (2000) describes a ladder approach to integration of content in a curriculum. This integration ladder lists 11 points on a continuum from isolation progressing through harmonisation to end with a transdisciplinary approach to teaching and learning. The ladder approach describes the extent to which individual sections of teaching and learning interact with each other, from no interaction (isolation) to between different disciplines (multi-disciplinary) and ending in interaction occurring in the students’ minds (trans-disciplinary). It is difficult to assess how integrated the FPC is and indeed its position on this ladder.

The curriculum can be thought of as being integrated as shown by the method of its assessment. The curriculum requires trainees to evidence that they are acquiring the required competencies using an electronic portfolio (e-portfolio). The e-portfolio lists specific core procedures that a Foundation Year trainee has to have evidence of completing in order to pass the year at their Annual Review of Competence Progression (ARCP). These procedures, such as interpretation of an ECG, requires parallel knowledge of clinical sciences such as physiology (to understand how an ECG trace is produced) and cardiology (to understand what each section of the ECG trace means). As completion of these competencies is mandatory to pass the ARCP, it indirectly leads to an integrated curriculum.

Regarding the position of the curriculum on the integration ladder, the curriculum, if viewed as a syllabus, does not explicitly require trainees to have teaching by other health professionals. If this did occur, then it would meet at least the multi-disciplinary stage of the integration ladder. However, in practice, some teaching may be delivered by nurses and other allied health professionals, and this may be assessed through a trainee’s e-portfolio by senior clinicians at the ARCP. This ambiguity, amongst others, mean that it is difficult to accurately pinpoint the degree to which the curriculum is integrated if viewed through the lens of a specific ladder. However, given that the FPC places a large emphasis on the trainee’s ability as a self-reflective learner, it may be that the curriculum is at the upper end of the integration ladder.

Malik and Malik (2011) recognise that integration can be both vertical and horizontal in nature. Vertical integration is described as being the integration between sessions that are taught in different parts of the curriculum. Horizontal integration is that which occurs between specific fields of knowledge, such as between biochemistry and medicine when carrying out a urine dip test to diagnose a urinary tract infection. Whilst the FP teaching programme at an individual teaching hospital trust may plan for vertical integration, in practice, it may be that clinicians who are not directly involved in the education of trainees deliver individual teaching sessions. As a result, the extent to vertical integration may depend on individual clinicians being aware of the curriculum they are helping deliver and the prior knowledge of the trainees. Therefore, whilst the FPC is planned to be integrative, it is difficult to assess how integrated it is in practice, at the point of delivery in an individual hospital.

How does the FPC achieve its aim?

The aim of the FP is essentially to prepare new medical graduates to enter speciality or general practice training. This aim is achieved by acquisition of competencies which are divided into four sections which are similar to the four domains stated in the GMC’s Good Medical Practice (GMC, 2013). The sections are: professional behaviour and trust, communication, team working and leadership, clinical care and safety and quality (UKFPO, 2016). These domains contain 20 descriptors of competencies, which could be termed broad learning outcomes, that trainees are expected to meet in order to pass their ARCP.

The FPC places a great deal of emphasis on effective communication between trainees and patients. This is reflective of the high expectation that patients have of their doctors. According to Ipsos (2017) data, doctors are amongst one of the most trusted professions in the public’s view. This results in a great responsibility upon doctors to maintain this trust in order to enable patients to trust doctors with their confidential health information. However, it is important to note that this
The formal curriculum is outlined by Howard et al. (2012) as the material that is taught to students in lectures and seminars, whereas the informal curriculum is the impromptu teaching that is delivered by those teachers who are not directly attached to the core faculty. These two parts of the curriculum may appear to encapsulate the majority of teaching within a curriculum. However, as Howard et al. (2012) go on to explain, whilst trainees may gain some benefit from a formalised ethics based teaching program, it appears that formal classroom based ethics based teaching is preferred less by trainees than more concrete clinical teaching. This negative perception may translate into poor feedback to program administrators and so may inadvertently relegate ethics teaching to either the informal or hidden curriculum. The informal curriculum was examined by Hundert, Hafferty and Christakis (1996) and found to be the teaching that occurs around the formalised teaching, such as the instruction received by trainees by seniors just after a lecture has finished. In addition, the informal teaching may include the peer to peer teaching that occurs by senior trainees to their junior counterparts. Hundert, Hafferty and Christakis (1996) encourage using the informal curriculum to supplement the formal curriculum in ethics based teaching. They do this by encouraging learners to discuss such topics outside of the lecture theatre, in more informal settings such as oncall rooms or doctors’ offices on the wards.

The formal and informal curricula and the discussion around them appears to account for the majority of professionalism teaching that is received by medical students. However as Howard et al. (2012) explain, the hidden curriculum is the knowledge which cannot be articulated in some form of formal or informal instruction method. As a result, it may be that students learn professionalism from their seniors, such as professors at medical school or consultants when students are on their placements. It is pertinent to note that the hiddenness of the hidden curriculum is with regards to its implicit nature rather than any hidden agenda as explained by Ssebunnya (2013).

The hidden curriculum has been attributed by MacLeod (2014) as being the vehicle through which students acquire professional values within the umbrella of medical education. MacLeod (2014) describes hidden curricula as being the area where concepts are grouped together which may not be explicitly taught to students. This implies that the hidden curriculum is a nebulous concept and as a result may be defined differently by individual medical educators. This variation in definitions may affect the delivery of the hidden curriculum and by extension the sections of the overall curriculum which interact with it.

As FP trainees are to some extent a product of the medical schools from which they graduate, it may be relevant to briefly explore how values are taught to medical students. Ssebunnya (2013) argues that the shift towards scientific and
There are a number of assessment methods to assess a trainee’s clinical acumen and their performance. The FPC focuses on reflective practice, with evidence of this required in the e-portfolio and therefore needed to complete the ARCP. Subramanian and Longson (2012) found that the top priority for trainees regarding portfolio use was to pass their ARCP. However, this same piece of research demonstrated that the second priority for trainees using the portfolio system was its use as a learning tool. This is somewhat reassuring as it shows that the e-portfolio is being used as evidence of trainees meeting the competencies that are detailed in the FPC.

The trainer’s report forms a crucial part of a trainee’s assessment and through it supervisors are able to give feedback in order to allow the trainee to improve. However, as trainees move placements, and as result move wards (usually every four months), there is a break in continuity of clinical supervision of a Foundation Year trainee. The FPC does require a trainee to have an educational supervisor for each year. However, in practice interaction between an educational supervisor and their trainee occurs far less than interaction between a trainee and their clinical supervisor. The discontinuity between clinical supervision can also occur within a four-month placement due to differing shift patterns and so this can limit regular contact between a clinical supervisor and their trainee. The effect of the limitation in regular trainee-supervisor contact on assessments, like those mentioned above, was explored by Cheung et al. (2017). They state that the irregular contact between clinical supervisors and trainees may inhibit supervisors from giving negative criticism. This reluctance to give negative feedback is compounded by a presumption by supervisors that previous supervisor reports were satisfactory, further reducing the likelihood of a negative supervisor report being given. As a result, trainees may fall into a false sense of security regarding their level of clinical competence and hinder improvement of their clinical acumen. Cheung et al. (2017) go on to state that the quality of workplace-based assessments depends on the quality and depth of the educational relationship between supervisor and trainee, termed the educational alliance. It may be difficult to determine the exact effect of the strength of this alliance on the electronic written assessments that are required by the FPC.
What are the methods of quality assurance of the FPC?

There are many methods of curricular control and refinement that exist in order to ensure that a curriculum is appropriate for the environment in which it is being taught. As part of satisfactory sign off in the ARCP, trainees are required to complete feedback forms on the placements that they have rotated through as a means of evaluation. This evaluation tool can be used as a quality management tool to allow for refinement in the delivery of the FPC. It asks, amongst other factors, the view of trainees on scheduled teaching and support in a training post. However, as Higgins, Cavendish and Gregory (2006) report, teaching sessions involving Foundation Year trainees can be poorly attended, due to service provision requirements. They state that this can negatively affect the delivery of the FPC. It is difficult to see how this can be mitigated centrally by the UKFPO as there may be local problems with service provision which may require a local solution in order to improve the training environment of trainees.

The FPC is no exception to regular revision by stakeholders, such as the regulator of doctors in the UK, the GMC. The GMC regularly produce guidance for standards in postgraduate medical education and these recommendations are intended to improve the quality of postgraduate medical education. The GMC requires all doctors in training to complete an annual National Training Survey. This is one of the methods that the GMC employ to quality assure GMC-approved training programmes, such as the FP. Data from this survey is shared with other stakeholders, such as Health Education England and Deaneries, who are responsible for delivery of the FPC. This enables collaboration to find a way of improving the delivery of the curriculum.

The FPC has many stakeholders and given the number of stakeholders this may lead to competing agendas with regards to the design of the curriculum. Wong (2012) explores how different stakeholders can collaborate in order to develop a postgraduate medical education curriculum in Canada using the Delphi technique. This technique is described in the literature as an effective tool to reach a consensus on the competencies required for a curriculum. Additionally, this technique avoids tensions that can occur with face-face meetings by collaborating electronically using forms and questionnaires. This appears to be an effective way of avoiding tensions that can occur with physical meetings to decide content for curricula, however the FPC does not explicitly state the method used to reach a consensus on which competencies to include. However, it does state in the bibliography, documents which have been used to shape the curriculum, such as the competency framework of the Academy of Medical Royal Colleges (UKFPO, 2016). The curriculum proposed by Wong (2012) is for an outpatient setting in Canada which is a different working environment than that of the FP in the UK. Therefore, whilst it does demonstrate an innovative approach to designing a curriculum through collaboration with many stakeholders, perhaps further research in this area is needed before it can be applied as a way of refining the FPC.

Conclusion

The FPC was devised in response to a need to improve postgraduate medical education. The need to improve the educational climate for medical graduates was identified by the CMO of the UK at the time. Policy that was produced by the Department of Health recommended a two-year rotational programme with a spiral curriculum extending through both of these years as a way to streamline the early part of postgraduate medical education. The primary aim of the FPC was to enable doctors to develop their professional and clinical skills in order to proceed to the next stage of training. The mechanisms through which the curriculum is delivered may not always be through formal means and some of the more difficult topics may be explored through the hidden curriculum. The assessment of the FPC can be of variable quality depending upon the supervisor allocated to a specific trainee. The FPC has various quality control mechanisms, such as trainee evaluation tools, in order to identify problems and take steps to solve issues once they have been identified. In my opinion, the FPC has been shaped by various educational, social and political influences in order to produce an appropriate curriculum which allows trainees to develop as clinicians in order to enter the next stage of training.

Take Home Messages

- The FP is a common bridge in the UK that medical graduates have to cross before entering into speciality training
- The FPC is a postgraduate medical curriculum that is designed to allow trainees to acquire the necessary knowledge skills and attitudes to progress into the next stage of their training
- The FPC can be thought of as an integrated spiral curriculum
- The FPC has various assessment strategies to determine if trainees have met the aims of the curriculum
- The hidden curriculum is an important aspect to consider when analysing a curriculum
Notes On Contributors
Hassaan Waqar is a General Practice trainee in Birmingham in the United Kingdom with an interest in Medical Education and General Practice.

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The author has declared that there are no conflicts of interest.

Ethics Statement
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Bibliography/References

Cheung, W.J., Dudek, N.L., Wood, T.J. and Frank, J.R. (2017) Supervisor-trainee continuity and the quality of work-based assessments. Medical Education. 51(12), pp. 1260–1268. Reference Source

Dale, J., Sandhu, H., Lall, R. and Glucksman, E. (2008) The patient, the doctor and the emergency department: A cross-sectional study of patient-centredness in 1990 and 2005. Patient Education and Counseling. 72(2), pp. 320–329. Reference Source

Dent, J. and Harden, R.M. (2009) The integration ladder: a tool for curriculum planning and evaluation. Medical Education. 34(7), pp. 551–557. Reference Source

Harden, R.M., Davis, M.H. and Crosby, J.R. (1997) The new Dundee medical curriculum: a whole that is greater than the sum of the parts. Medical education. 31(4), pp. 264–271. Reference Source

Higgins, R., Cavendish, S. and Gregory, R. (2006) Class half-empty? Pre-registration house officer attendance at weekly teaching sessions: implications for delivering the new Foundation Programme curriculum. Medical Education. 40(9), pp. 877–883. Reference Source

Howard, F., McKneally, M.F., Upshur, R.E.G. and Levin, A.V. (2012) The formal and informal surgical ethics curriculum: views of resident and staff surgeons in Toronto. American Journal of Surgery. The. 203(2), pp. 258–265. Reference Source

Hundert, E.M., Hafferty, F. and Christakis, D. (1996) Characteristics of the informal curriculum and trainees' ethical choices. Academic Medicine : journal of the Association of American Medical Colleges. 71(6), pp. 624–642. Reference Source

Jyothirmayi, R. (2012) Case-based Discussion: Assessment Tool or Teaching Aid? Clinical Oncology. 24(10), pp. 649–653. Reference Source

Malik, A.S. and Malik, R.H. (2011) Twelve tips for developing an integrated curriculum. Medical Teacher. 33(2), pp. 99–104. Reference Source

Miller, G.E. (1990) The assessment of clinical skills/competence/ performance. Academic medicine : journal of the Association of American Medical Colleges. 65(9 Suppl), pp. 63. Reference Source

Ssebunnya, G.M. (2013) Beyond the hidden curriculum: The challenging search for authentic values in medical ethics education. South African Journal of Bioethics and Law. 6(2), pp. 48–51. Reference Source

The Foundation Programme Committee (2005) Curriculum for the foundation years in postgraduate education and training. Available at: Reference Source (Accessed: 24/08/18)

The Lancet (2005) Medical education in the UK: building a firm foundation. The Lancet. 366(9486), pp. 607. Reference Source

UKFPO (2016) The Foundation Programme Curriculum 2016. UKFPO. Available at: Reference Source (Accessed: 24/08/18)

Wong, R. (2012) Defining Content for a Competency-based (CanMEDS) Postgraduate Curriculum in Ambulatory Care: a Delphi Study. Canadian medical education journal. 3(1), pp. e21
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Sateesh Babu Arja
Avalon University School of Medicine

This review has been migrated. The reviewer awarded 4 stars out of 5

I have no clue how the training programs work in the UK, and the procedures followed going into the specialty training there. However, I enjoyed reading this manuscript. The author started off with a small introduction and then explained the curricular models, assessments, and the quality control activities of the FP program. One of the most important concerns raised by the author is the delivery of the curriculum. The curriculum and syllabus is written well, but the delivery depends on the hospital and trust. I believe it is the same problem everywhere. The curriculum document might be written very well, but it depends on the effective delivery. Other concerns raised by the author are the hidden curriculum and the trainees' inability to attend teaching sessions due to service commitments. It is an excellent piece of reflective writing by a trainee who has the first-hand experience. This paper is useful for trainees and other stakeholders involved in quality control activities of the FP program.

Competing Interests: No conflicts of interest were disclosed.

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Ken Masters
Sultan Qaboos University
This review has been migrated. The reviewer awarded 4 stars out of 5

The paper is a personal critical analysis of the Foundation Programme Curriculum in the UK. The author has done well to produce a detailed analysis of the curriculum, including its rationale, history and implications in execution. The author has also situated the narrative within the appropriate medical education literature to produce a succinct and balanced appraisal of the curriculum. While there are times when those readers who have a more detailed knowledge of the development and application of the curriculum may feel that some detail is obscured, and some reference to the "political" aspects could do with a little more elaboration, it is important to remember that everything cannot be covered in such a review. A good and useful read.

**Competing Interests:** No conflicts of interest were disclosed.

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**David Bruce**
None

This review has been migrated. The reviewer awarded 3 stars out of 5

As a member of our local Deanery team who was involved at the start of Foundation training, I read and enjoyed this personal critical analysis of the Foundation Programme Curriculum (FPC). I think it will be of interest to medical students, Foundation doctors and those involved in the delivery and quality management of Foundation Programmes. The paper is wide ranging, covering the background to Foundation training in the UK, the curriculum aims, methods and assessments and quality assurance. The author is presenting a personal critical analysis using his recent experience as a Foundation trainee and educational theory and raises many interesting points. The author outlines the importance of a spiral FPC in allowing Foundation doctors to take on more responsibility as they progress in their training. I wondered if the difficulty in assessing the integrated nature of the FPC related to personal experience, as the 20 learning outcomes apply to the whole Foundation programme. Explaining how the learning outcomes are structured around the four GMC domains and highlighting the emphasis on patient centred care and good communication in Foundation training is helpful to the reader. The section on the hidden curriculum raises important points. The authors experience is that ethics and professionalism is not part of the formal or informal curriculum and is therefore left to the hidden curriculum. I suspect that this is not the case for many Foundation programmes across the UK. The importance of the hidden curriculum and the way norms and values are transmitted is highlighted. This section really makes the
case for increased attention to the quality of the educational environment and need for positive role models. However, for many a Foundation doctors the chance to meet and discuss ethical dilemmas with peers and seniors and experience how decisions are made will happen as part of the informal FPC. The assessment strategies as described gives food for thought for all involved in teaching. The supervised learning event (SLE) should be a protected period of time where a trainee gets to sit down with a trainer, discuss a case, and receive feedback on how they are progressing. If trainees perceive SLEs as hoops to be jumped through, then the value of this tool is diminished. The importance of good clinical and educational supervision is well made. I would have been interested to hear the authors view of the value of the Foundation multi-source feedback (TAB). I thought there were a couple of areas where this paper could be improved. The summary paragraphs about why the Foundation programme and FPC were introduced could be revised. The Calman reforms of the 1990s established secondary care specialty training and the introduction of Summative Assessment set standards for GP training. This then left a gap – the SHO posts, where doctors were not part of a training programme. Although in this system many doctors received high quality training in these posts, some worked in service posts with little training, hence the need for Foundation training. The politics of the introduction of Foundation Programmes and changes to regulation are probably out with the scope of this paper. The final section on quality assurance of the FPC mixes the feedback given by trainees about their Foundation programmes and the role of the regulator in quality assurance of the Foundation programme and actual review and changes to the FPC.

As stated, the author is to be commended for providing a paper that will be of interest to medical students, Foundation trainees and those involved in the delivery and quality management of Foundation training.

**Competing Interests:** No conflicts of interest were disclosed.

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Felix Silwimba
University of Lusaka

This review has been migrated. The reviewer awarded 5 stars out of 5

This is an excellent write up on postgraduate medical education preparations. It in a way explains the role of a curriculum in continuing medial education and making medical doctors' learners throughout their careers and beyond. Even though the write up describes medical education in the UK. I find it applicable in low income countries. I would equate the 2 years FP program to the ‘rural posting’ programs implemented in some low-income countries. Except that in such countries ‘rural posting’ is not officially
listed as part of medical education leading to admission to a postgraduate course. Therefore, it is difficult to separate medical education from the practice of medicine since the formal, informal and hidden curriculum are inseparable. I thank the authors for their work.

**Competing Interests:** No conflicts of interest were disclosed.