FY1 in heart failure: the good, the bad and the ugly!

Reflections by the FY1 doctors in heart failure and their supervisor on the first year of a new post

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With the expansion of the heart failure services to meet the rise in demand, we established, in Sheffield, a new training post for the junior medical staff in their first year of training. This is a four-month post for the Foundation Year one (FY1) doctors in heart failure. The post differs from the classic FY1 posts in that it is based in the heart failure multi-disciplinary team (HF-MDT) rather than being ward-based. Thus, the trainee works under the supervision of a consultant cardiologist with an interest in heart failure, and works alongside a group of heart failure specialist nurses screening new admissions for heart failure, and offering advice and follow-up of patients with heart failure who are not under the care of the cardiologists. The trainee attends the heart failure diagnostic clinic along with the consultant cardiologist, and participates in the work of the HF-MDT ward round. These are the collective personal views of the first three trainees who have worked in this post in the year 2013–2014; with a footnote from their supervisor.

Introduction

For newly qualified doctors, the Foundation Programme provides a stimulating and exciting entry into a career in medicine. As the name suggests, doctors work within a range of specialties and environments in order to build on the knowledge learnt at medical school, and develop as a clinician in preparation for specialty training. We had the privilege of being the first to work as foundation doctors in a new role – FY1 in heart failure – and, in this article, we hope to outline some of the joys and challenges we have encountered.

The heart failure (HF) service at Sheffield Teaching Hospitals[1] was run by a consultant cardiologist,* heart failure specialist nurses, a dedicated administration team, and from summer 2013, an FY1 doctor. The HF multi-disciplinary team (MDT) cares for inpatients and outpatients, and is linked to a community team of specialist nurses. Inpatients with HF on non-cardiology wards are referred directly to the HF service by the parent team using single point of access, and are seen by the specialist nurses (or the FY1 doctor). They offer the parent medical team

The three trainees and their supervisor. From left to right: Dr Sarah Soar, Dr Philippe Wheeler, Dr Laura Styles and Dr Abdallah Al-Mohammad

advice on HF management, and provide the patient with advice and support during their stay. These patients are seen on the weekly consultant cardiologist-led MDT ward round, and plans for further investigation and management are suggested. For HF outpatients, an MDT meeting is held where their cases are discussed and management plans are drawn up and communicated to the community nurses and general practitioners.

*From September 2014, three consultant cardiologists are working in the HF service.

Experience

It has been immensely rewarding to work as part of a well-developed MDT, in which vast experience and knowledge is pooled to achieve good outcomes for each patient. We have valued being able to work with and alongside such a team, which works efficiently and holds the patient as the centre of concern.

As an FY1, a large proportion of our time was spent seeing inpatients – either those newly referred to the HF service, or to review those already under the care of the team. As the year has progressed, we have each been able to contribute towards the remit of the FY1's role, and have been encouraged to engage in discussions on how the service is running. Through seeing the needs of patients from a fresh perspective, we've been able to impact on quality improvement in the service and see through those changes at a personal level. Throughout the rotation, we gathered information for the National Heart Failure Audit, and were also able to carry out audit projects of our own.

There have been plenty of opportunities for learning; through shadowing community HF nurses on home visits, attending HF clinics and during the HF MDT ward rounds and meetings. Learning has been one of the key positives of this role. In many junior doctor jobs, despite officially being in training post, the pressures of ward work mean that, in fact, there is little opportunity for learning. In this job, the FY1 is made to feel that they can take any opportunities that they like to further their education. With regard to HF specifically, while working in general medicine provides a basic overview of how to manage the disease acutely, there is little focus on management of the chronic disease, optimising medications or thinking about how the patient is going to be managed in the community. This job gave us an excellent insight into all aspects of the condition, and enabled us to see the importance of the input of many different healthcare professionals, both in the hospital and in the community.

Furthermore, we were given the opportunity to spend a few sessions with the community HF nurses and GPs with special interest in HF, the number of sessions in the community varied according to whether the FY1 doctor has a planned attachment to a GP practice in their rotation or not. This time helped us to see management plans made at our HF MDT meetings coming to fruition in the community, and we were given a real sense of the interface between primary and secondary care. Seeing patients in their own homes with the community nurses gave us a different insight to HF. We were able to see how a patient's care is optimised in the community to prevent them from becoming acutely unwell, and also how the specialist nurses work with the GPs to tailor care to individual needs.

In the hospital, we have had the opportunity to sit in on consultant-led clinics where new patients are seen with suspected HF. This was very useful in exposing us to a doctor–patient interaction, which most FY1s do not routinely get the chance to experience. It also allowed us to practice patient examination with good clinical signs, as well as get constructive feedback.

Issues

Much of the job involved mirroring the work of HF specialist nurses, but without that title. This could prove awkward at times. The most difficult part of the job was working out where you stand as an FY1 in HF, offering advice to other teams, as we didn't have any of the experience or reputation of the HF specialist nurses. However, by the end of the job, we certainly felt comfortable reviewing patients with HF and making suggestions regarding their management even though it could feel quite uncomfortable, when, as the most junior of doctors, we were offering advice to other medical teams. In areas where our role and the HF team were well known, we were met with respect and encouragement, and, in general, our advice would be well received. In other areas, however, medical staff would appear confused and a little hostile, when an FY1 doctor was sent to review a patient who they had referred to the specialist HF service. In these cases, we would seek advice from specialist nursing or cardiology colleagues, who would be able to back up our ideas. We felt that four months of working as an FY1 in HF alone was perhaps a little too much, especially as, when we had initially applied for the job, we were expecting to work in general cardiology. We were able to vary how we spent our time a little, by covering the cardiology teams when they were short-staffed, and spending time with the on-call cardiology team. However, being unbanded, we did miss out on the experience (and pay!) that other FY1 doctors in cardiology gained through doing general medical on-calls. Perhaps rotating through the HF team on two-monthly cycles with general cardiology would give more doctors the learning opportunities that we had in HF, while also maintaining acute ward experience.

Overall, however, we will look back on this post as being a positive experience. We were welcomed into the team and given every possible opportunity to further our education as junior doctors. It has served as a strong and unforgettable element of our 'foundations' as young doctors, and the skills and knowledge we have gained from this post will be transferrable wherever our careers take us.

Key messages

- The interface between community and hospital care is important in chronic disease management, and can be approached early in training
- A role in a specialist heart failure team helps trainees to fulfil learning requirements in managing chronic disease and its acute presentations
- Working within a specialist heart failure multi-disciplinary team (MDT) gives foundation trainees a broader perspective on disease management

Footnote

By Dr Abdallah Al-Mohammad

Several reasons drove me to propose this new post to our deanery (Yorkshire and Humber). First, there is a need to provide young doctors with the opportunity to learn the management of complex chronic illnesses associated frequently with multiple comorbidities and requiring input from a MDT. This is best exemplified by HF. The skills gained in the process are usually acquired much later in the medical career, but there is no reason why that couldn't be brought forward. Those skills are transferrable irrespective of their future career aspirations. Second, I wanted to provide them with the opportunity of working in both primary and secondary care even though the post is mainly in a secondary-care setting. Third, HF is increasing in prevalence for many reasons, and is likely to rise due to the pending expansion of the octogenarian population in this country, who have almost 10 times the prevalence of HF in the younger age groups, and I wanted to spread the seeds early on in the career of some medical trainees, so that they will be ready to face the changes that are on the horizon. Some of them may take up medicine as a career, either in primary or secondary care, and would hopefully benefit from this early experience.

The feedback from these three trainees has certainly been very helpful in guiding further development of the post. The potential feedback from the *BJC*'s readership would not only help us locally in developing the post, but may create a helpful debate into the shape of medical training and its delivery

Conflict of interest

None declared.

Reference

1. Sheffield Teaching Hospitals NHS Foundation Trust. Sheffield's Heart Failure MDT (Outreach service into non-cardiology wards). Shared Learning Databases on the NICE. org website, November 2014. Available from: http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fsl_808