The Imperfect Foundations of the Foundation Year Experience

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Foundation Year doctors in the NHS face an educational landscape fraught with challenges. Recent data from the GMC's National Training Survey reveal that although 86% of trainees felt positively about clinical supervision and 83% judged their overall experience as good or very good, burnout risk continues to rise: 23% of trainees now face a high risk of burnout, its highest level since 2018. Fewer than half of trainers (46%) report having sufficient time to devote to education, and around one-third believe rota gaps harm trainee development.[1]

Similarly, a thematic analysis of newly qualified doctors found that burnout is frequently linked directly to Foundation Programme conditions: excessive workload, lack of support, and disorientating role transitions. Community cohesion, meanwhile, was viewed as a rare protective factor.[2] Stress and burnout during the pandemic years were strongly associated with increased hours, poor leadership, and not feeling valued.[3]

Such findings validate the lived frustrations of junior doctors: unclear inductions, repetitive online lectures, duplication of content, and minimal in-person, case-based teaching. These deficits undermine learning, morale, and ultimately, patient care. Research linking perceptions of supervision and rota design to patient mortality underscores the urgency of reform.[4]

This essay explores how a once-robust culture of in-person teaching has largely disappeared and how modern solutions, including AI-based support and increased staffing, could restore meaningful educational environments rooted in distributed cognition.

Personal and Intergenerational Reflections

My experience as a newly qualified doctor has been a sobering contrast to the stories I've heard from those who trained before me. I am currently based at Imperial College Healthcare NHS Trust, often hailed as a centre of excellence in medical education. Yet in my twelve months there, I have received only three consultant led lunchtime teaching sessions. There has been little time for meaningful engagement. Mandatory Thursday teaching sessions, when held, have been unstructured, repetitive, and almost always online. I have sat through the same lecture repeated on at least four separate occasions.

During my Advanced Life Support course, [5] I had the opportunity to speak with several senior consultants and registrars about how things used to be. They described a time when service provision hadn't yet consumed every waking hour of a doctor's day. Senior registrars would lead proactive, clinically focused teaching sessions for junior doctors face-to-face,

often over lunch provided by the hospital. It wasn't just an opportunity for education; it was a space to build rapport, ask questions, and develop mutual respect. It sounded more like an apprenticeship than the disjointed model we now find ourselves in.

This aligned with what my father, a consultant psychiatrist who has worked in the NHS for over 40 years, has always told me. During his junior doctor years in the 1980s and '90s, he recalls mandatory one-hour departmental teaching sessions after every ward round. Consultants were not merely senior clinicians; they were teachers and education wasn't treated as an 'extra', rather embedded into the working day.

Contrast this with the modern NHS: no post-ward round teaching, occasional virtual sessions, repetitive content, and poor engagement. Supervisor constraints and rota design pressures further limit training time: 33–40% of trainers across specialties report that rota gaps adversely affect education, and only 46% say they can reliably use allocated teaching time.[1]

These intergenerational comparisons highlight just how much the structure and culture of medical education have deteriorated. What was once embedded in the rhythm of clinical life has now become optional, digital, and increasingly disengaging. From my experience, it is not that senior clinicians no longer want to teach, it is that the system no longer allows for it. Without time and structure, teaching disappears. And with it, so too does the confidence and competence of junior doctors like myself, left to learn in the margins of an overstretched and under-resourced NHS.

Research Context: Theoretical Foundations

The theory of distributed cognition, developed by Edwin Hutchins, posits that cognitive processes are not confined to individuals but are distributed across people, tools, and artefacts within a sociocultural system.[6] In clinical settings, this is evident when teams interact with different information sources (vital signs, imaging, medication charts) and collectively reason through patient management.[7]

In acute care domains, video-reflexive ethnography (VRE) has shown that collaborative clinical reasoning improves decision-making, safety, and learning when multidisciplinary teams interact deliberately and reflectively.[8] Ward rounds designed with distributed cognition principles, where each team member contributes distinct insights, facilitate shared decision-making, cross-checking, and safety back-up networks.[9] Similarly, structured interdisciplinary bedside rounds consistently improve team communication, patient satisfaction, and safety outcomes when compared to siloed individual rounds.[10]

The Wand in the Room: AI and the NHS's Accidental Luddism?

Let's talk about the wand in the room.

Not the plastic sort you'd find in a gift shop. I mean the sleek, humming, spell-suggesting, data-consuming 'Wand', our modern metaphor for Artificial Intelligence. A technology so

advanced that, to the average NHS Trust, it might as well have emerged from Ollivander's wand shop, humming with eldritch power and terrifying bureaucracy in equal measure.

AI today holds the same transformative power that a wand holds in the magical world. Yet in the NHS, we've taken this miraculous tool and locked it in a drawer next to the fax machine, just in case it's "too disruptive".

Imagine a hospital as Hogwarts, but with fewer talking portraits and more malfunctioning label printers. The ward round begins. Consultant McGonagall (MBBS, FRCP, and chronically underslept) strides in, trailed by the registrar, SHO, and medical student. Each clutches a portable computer on wheels, praying the Wi-Fi holds out.

And there it is, the AI Wand, glowing softly. It could, in theory, dictate flawless ward round notes, draft discharge summaries, cross-check drug interactions, summarise handover notes, and maybe even locate the missing patient. But no one touches it. Why? Because the NHS handbook (last updated during the Blair era) doesn't explain how to log in. The password's expired. The Trust firewall blocked the update. IT is "looking into it".

So instead, the round stumbles forward. The SHO stares at the meds chart for five minutes. The registrar sways through the endless documents from the patients overnight admission. The consultant, who should be teaching, is busy being the team's designated human scribe. No cognition is distributed. Everyone is too tired. Learning is postponed to a lunchtime that never comes.

What's tragic isn't that AI can't help, it can. It's that our system refuses to trust anything not vetted by a two-year committee and a 32-page PDF. Meanwhile, junior doctors are drowning in service provision, registrars have no time to teach, and the only thing that works efficiently is the water fountain.

Practical Proposals: Making the Magic Real

a) **Expand the Workforce**
We must hire more doctors. Filling rota gaps and increasing registrar availability restores capacity for teaching. As GMC data show, many trainers lack time to use their designated training hours and rota gaps limit high-quality supervision. [1] Increased staffing not only improves service continuity but enables registrars to teach proactively, not reactively.

b) **Integrate AI-Powered Support Tools**
AI systems should be deployed to automate administrative tasks. Prescribing checks, discharge summary drafting, blood result tracking, and documentation formatting can be reliably automated with oversight. This reduces cognitive load and error risk while freeing clinicians to focus on decision-making, supervision, and education. While the AI tool I am describing may not be ready just yet, in the UK, the rapid evolution of the technology the NHS should be ready and awaiting its release for trial and adoption there are currently AI

tools being developed for separate use such as clinical decision support or handover support but there remains a glaring hole for integrated AI assistants.

c) **Restore In-Person Clinical Teaching**
Departments should mandate daily, in-person teaching sessions following ward rounds, similar to my father's training era. These should be interactive and case-based, scheduled into rotas. Consultants and registrars should present real cases, pose questions, and encourage discussion. Modest incentives, like lunch, can foster attendance and collegiality.

d) **Formalise Distributed Cognition in Rounds**
Revive ward rounds using distributed cognition principles, ensuring multiple team members contribute and reason collectively. Research shows such rounds reduce errors and enhance efficiency and learning. Protocols should define roles and ensure participation from all levels, from consultant to student.

Conclusion: A Call to Action

The educational experience of Foundation doctors today is hampered by excessive service demands, limited in-person teaching, burnout, and strained supervisory structures. Evidence shows that perceptions of rota design and supervision correlate directly with both trainee wellbeing and patient safety. Meanwhile, distributed cognition and interdisciplinary bedside rounds offer robust models for safe, efficient, and educative ward practice.

Reclaiming the lost art of clinical teaching in the NHS requires two urgent reforms: increase staffing to allow meaningful supervision, and embrace AI to offload the clerical burden. Together, these would enable a return to the kind of in-person ward rounds that educate, engage, and empower juniors, reviving the interprofessional dialogue that builds confidence and competence.

Imagine Hogwarts Hospital once more alive with bedside discussion: mentors guiding, juniors questioning, cognition shared, AI unobtrusively supporting in the background. This is no fantasy. It is tested theory and lived practice, if we are bold enough to invest and innovate.

By arguing for a realistic, evidence-based restoration of departmental teaching, supported by AI and workforce planning, we offer a blueprint not only for better junior education, but for a safer, more sustainable NHS.

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