The journey through medical training is full of significant transitions and changes in the responsibilities and seniority levels of trainees. Many articles examine the early transition from a medical student to a newly qualified doctor. Nonetheless, few studies were designed to investigate the impact of on-going transitions following the completion of the first year as a postgraduate doctor and transitions at higher levels of training. We aimed to explore the extent to which core medical trainees in their second (final) year (CMT2) feel prepared and confident about starting their higher medical training.

METHODS
In 2013, a pretested questionnaire was sent to all CMT2 in the sector covered by University College London (UCL) partners. The total number of eligible trainees was 88. Thematic analysis was applied to qualitative data.

RESULTS
The survey was completed by 53 trainees (60.2%). While the vast majority of the CMT2s (88.7%) completed the Membership of the Royal College of Physicians (MRCP) exam, 25 (28%) revealed that they had insufficient confidence to become registrars. This confirms the previously reported finding that a positive relationship between competence and self-perceived confidence is often absent.

The trainees expressed concerns across a wide range of clinical and non-clinical domains. It appeared, however, that practical procedures constituted the major area of lack of confidence, followed by managing cardiac arrest calls, running outpatient clinics and responding to referrals from other specialties. The trainees primarily blamed the low volume of exposure to these activities during the training programme. This resembles the association of the lack of confidence with ‘low volume/high impact’ clinical activities described by Kneeborn.

The majority agreed that their job was more of a ‘service provision’, as opposed to being a training role reflecting that the CMT2s are rather distracted by jobs which are less suited for them. The lack of flexibility of placements and inadequate exposure to certain specialties was considered by many trainees as another important reason behind their insufficient confidence.

| Table 1: The different suggestions proposed by the core medical trainees to improve their overall confidence. |
|----------------------------------|
| Suggestion Themes              |
| A period of ‘acting up’ as a Medical Registrar: |
| - Opportunities to shadow registrars. |
| - Encouragement to step up to fill registrar on-call shifts towards the end of CMT once full MRCP is obtained. |
| More opportunities to achieve confidence in specific areas: |
| - More free courses aimed at practical skills. |
| - Fixed Leave/time out of work to improve confidence in certain skills. |
| - Protected, allocated and compulsory clinic time across all rotations. |
| Improving and reforming CMT teaching: |
| - Incorporating simulation training. |
| - More practical teaching in protected teaching sessions. |
| Service and placement rearrangement: |
| - Incorporating specific mandatory placements into the CMT programme that would allow building up confidence in generic skills (ITU, Acute Medicine, Renal). |
| - CMT2s to have more junior doctors doing the basic ward jobs. |
| Others |
| - Regular consultant and registrar feedback during the medical take. |
| - CMT2s to be recognized as preparing to become registrars and not as junior doctors. |
| - More clear definition of roles on the ward (CMT trainees versus Foundation doctors). |

The recommendations made by the CMT2s are summarised in Table 1. The primary suggestion was a period of shadowing or ‘acting up’ as medical registrars and greater opportunity to take referrals during the acute take. This suggestion remains plausible particularly as the concept of shadowing of near peers has been successfully used at lower-level transitions (such as students shadowing foundation doctors) and was proved to enhance preparedness levels. Alternatively, the trainees felt that simulation teaching could be a good compromise. In addition, the trainees expected to have more opportunities to improve their confidence in specific areas by taking ‘time out’ through fixed leave or allocated slots. Others suggested full rearrangement of the service and the CMT rotations by having more juniors (foundation doctors) to which tasks could be delegated. They believed that this should be combined with clearly defined roles of the CMT2s, as well as separation from the roles of foundation doctors and GP trainees, who are less committed to medicine. Although a few CMT2s indicated that they would be more satisfied with an extension of the CMT, this was challenged by the majority of the trainees. 
CONCLUSION

This survey highlighted a number of areas of insufficient confidence and generated relevant solutions. However, further in-depth studies are required to explore the methods of implementing these recommendations.

Ahmed Hashim1 & Nina Salooja2

1 Gastroenterology Specialist Trainee, Brighton & Sussex University Hospitals, Eastern Road, Brighton BN2 5BE ahmedsir37@hotmail.com
2 Consultant Haematologist, Hammersmith Hospital, Du Cane Road, London, Greater London W12 0HS nina.salooja@imperial.ac.uk

REFERENCES

1. Wijnen-Meijer M, Kilmister S, Van Der Schaaf M, Cate OT. (2012) Impact of various transitions in the medical education continuum on perceived readiness of trainees to be entrusted with professional tasks. Med Teach. 2012; 34(11):929-35.

2. Cave J, Woolf K, Jones A, Daure J. Easing the transition from student to doctor: How can medical schools help prepare their graduates for starting work? Med Teach. 2009; 31(5):1-6.

3. Morgan, PJ, Cleave-Hogg D. Comparison between medical students’ experience, confidence and competence. Med Educ. 2002; 36(6):534-9.

4. Kneeborn R. Simulation in surgical training: educational issues and practical implications. Med Educ. 2003; 37(3):267-77.

5. Turner SR, White J, Poth C. Twelve tips for developing a near-peer shadowing program to prepare students for clinical training. Med Teach. 2012; 34(10):792-5.

A PILOT OF THE USE OF VOICE RECOGNITION SOFTWARE IN AN ENDOCRINE OUTPATIENT CLINIC

Editor,

Voice recognition software (VRS) has increasingly been utilised to document clinical care, typically within an electronic health care record and often with the use of ‘templates’. This software has been purported to enhance doctor efficiency, reduce costs and improve patient care1. The aim of the current pilot was the mandatory adoption of VRS embedded into electronic clinical documentation within a new patient endocrine clinic.

METHODS

Dragon Medical Practice Edition 2 speech recognition software manufactured by Nuance was installed onto a single office computer; a run in period of two months was required to optimize user dictation. Prior to clinic attendance, each patient had a voice activated clinic template note constructed online within Patient Center. The online medical note was then re-opened and typed in real time during the patient consultation. Once constructed, the outpatient note was reviewed, formatted (by typing and/or VRS) then authorised with an electronic signature.

RESULTS

Data from 24 consecutive medical notes were collected before and after the implementation of VRS. The use of VRS resulted in all of the outpatient medical notes transferring to an electronic/online version. The setup time for VRS was one minute per clinic letter, the existing process did not require any set up time. The total time allocation per clinic visit was similar (n=25 minutes) per patient for both processes (included obtaining a history, examination, medical note documentation and discussion with the patient). VRS improved the number of clinic letters appearing on NIECR on the day of clinic attendance (24 v 2, p=0.01) in comparison to the existing process. There was an improved mean turnaround time with VRS from day of clinic to the completion of clinic letter (7 v 25 days, p=0.01) appearing on NIECR in comparison to the existing process. Total clinician online medical note typing time was 7 minutes per patient in comparison to the existing process which did not require any time for clinician typing. The mean dictation time for the existing process per clinic letter was 1.5 minutes in comparison to 3 minutes using VRS. One new patient clinic (n=6 patients) resulted in savings in secretarial transcription time on average 30 minutes per clinic session.

DISCUSSION

Current upgraded versions of VRS have allowed the transcription of speech into written text with speed and accuracy2. The use of VRS enabled the process of construction of the electronic outpatient clinical note into a single step and resulted in ‘same day letters’, improved turnaround time and subsequent accessibility of clinic letters. The online letters could be accessed remotely and out of typical working hours if required. Advantages of the use of VRS include reducing errors in dictation and in illegible handwritten notes. Disadvantages commonly encountered are lack of accuracy and misinterpretation. The use of the software can be time consuming initially and prone to errors with background noise3. VRS has the potential for additional roll out in other outpatient settings and in streamlining and easing the burden of the written outpatient clinic note.

Riyas Perringattuthodiyl, Tristan Holdsworth, Philip C Johnston
Regional Centre for Endocrinology and Diabetes, Royal Victoria Hospital, Belfast, UK

Correspondence: philip.johnston@belfasttrust.hscni.net

REFERENCES

1. Bergeron BP. Voice recognition in clinical medicine: process versus technology. J Med Pract Manage 2001; 16(4):213-5.

2. Henricks WH, Roumina K, Skilton BE, Ozan DJ, Goss GR. The utility and cost effectiveness of voice recognition technology in surgical pathology. Mod Pathol 2002; 15(5):565-71.

3. Hodgson T, Coiera E. Risks and benefits of speech recognition for clinical documentation: a systematic review. J Am Med Inform Assoc. 2016; 23(e1):e169-79.