

# My journey so far, and where I'm going now

Éabha Lynn, Student Editor

Medicine is a remarkable discipline. What a gift it is, to be able to alleviate suffering, to be trusted with people's stories and with people's darkest days. It has been a privilege to spend these past few years beginning to learn the skills of medicine, right here in Lancaster. As a first-generation medic, I didn't know doctors growing up. Rather, I thought that the work clinicians did was nothing short of magical, that people like me just didn't, or couldn't, do things like that.

The study and practice of medicine are not ingrained in the culture I come from, but the sharing of stories certainly is. The sharing of stories, be that from patient to clinician in the clinical consultation, or between colleagues through journals like this one, enriches our work and our experience of medicine. Curiosity makes the mundane magical, and I am convinced that it makes us better clinicians too.

My granny is one of the cleverest women I know. She never attended university herself, but embedded within me a lifelong love of learning and an appreciation for education I trust will never leave me. I'm grateful for every opportunity to learn, from completing my schoolwork at the kitchen table in my grandparents' house to working within the BMJ education team at BMA House in London, to hopefully completing my undergraduate medical education in the next couple of years.

This love of education forms the backbone of my primary research interest. Despite being early on in my career, and malleable to change as I progress throughout and beyond my studies, my research so far has centred on medical education and medical students' wellbeing. Unusually for a medical student, most of the research work I have done so far has been qualitative. I think that what I love is the sharing of stories and the value of learning by and through lived experiences. Given I am still a student myself, I have taken a keen early interest in teaching, and am fond of planning and delivering teaching as well as simply studying medical education. The role of a "medical student" is itself such an interesting one. We are such a heterogeneous group, from fresh-faced 18-year-olds who have just finished school, to established professionals who have returned to medical school as graduates or mature students. The learning we do is so unique too, learning about the pathogenesis of disease, how the human body works and does not work, alongside learning the laws and ethics that govern our practice, the psychological and social context within which we work, and the public health and research practices that form the groundwork of our best practice when we complete our training and become autonomous clinicians in the more distant future. Throughout my career, I look forward to further developing these interests, focusing on the experiences of medical students from non-traditional backgrounds as they progress through and beyond medical school. Every student should be empowered to succeed in medicine, and this profession should be accessible and affordable to all those who wish to enter and work for it, no matter what their background.

All the gratitude in the world has offered no assistance when it comes to committing to a discipline though. I remain, as the old cliché says, "a jack of all trades, master of none." At school, my A-level subjects were split evenly between sciences and humanities, with the latter eventually outperforming the former come results day. My initial motivation for choosing medicine came from the belief that it was the best way to combine those interests – I'd be able to apply my scientific knowledge to humanity. When I arrived at medical school, and the intensity of the pre-clinical science sank in, I kept in touch with writing through music criticism, a far cry from medical journalism. This inability to choose a discipline has remained throughout medical school, but while I have yet to find my place within the world of clinical medicine, I am pleased to have found a home within editorial work.

My first editorial job was my current role at the BMJ, looking after all the content BMJ Student has produced this academic year. The range of work, spanning podcasts and written word, created by and for medical students from all over the world, has inspired me every day. I have learned so much, and I now look forward to taking this learning to the Morecambe Bay Medical Journal. The rewards of editorial work are more subtle than those of practising clinical medicine. When you are editing, you aren't restoring eyesight, you aren't delivering any babies, or sitting with anyone in their suffering. You are, however, taking an idea and moulding it into a publication. There is reward in seeing ideas flourish, in polishing them up to help them to shine. Uniquely, in my current role as editorial scholar and in my new role as student editor, I will often sit with my colleagues as they work towards their first academic publications, a valiant milestone in the career of any budding clinical academic clinician.

I am confident that the Morecambe Bay Medical Journal has a bright future ahead. The commitment and expertise of Ms Ahmed's leadership is radiant, and the enthusiasm felt from my fellow students at Lancaster Medical School is already inspiring. I look forward to bringing the journal to a wider audience of students, hopefully fostering collaboration with our colleagues studying at the Universities of Cumbria and Central Lancashire. I hope to bring the MBMJ onto social media shortly. Perhaps more important than my goals for the journal, are yours. What do you wish to see from us? What matters to you?

If you are thinking of writing for us, but don't know where to start or whether you should, heed this advice: You belong here. You have a voice, use it. When you are writing about what you love, it shows. You are always a better writer when you are writing about something you care about, your love for your subject is infectious. Know who your audience are and write to them. In this journal, your audience is your colleagues. Write as though you are writing to a colleague in the mess, or a friend in the year behind



you. Often editorial work is subjective, so knowing your editor and what they like and dislike helps – the easiest way to find this out is through reading and following your journal's guidance for authors. Editors are on your side. You are welcome to ask your editor if you don't understand a piece of feedback, and being open to and receptive of the feedback you receive can make the process smoother and a publication more likely.

Even after all this time, I don't picture myself when I think about what a medical student looks or sounds like. I have often felt out of place in this profession, worlds away from the tiny village I grew up in. Yet, the longer I spend at medical school, or working on medical journals, the more I realise there is no one way for a medical student to look or sound. As a profession, and as the future of the profession, we should resemble the population we serve.

I care deeply about patients, and I care deeply about medical students too. More often than not, our interests align. It is a difficult time to be a patient; waiting lists are growing, and so are health inequities. It is also a difficult time to be a medical student. We have less job security than ever before, less financial support during our studies than the generations that came before us, and lower pay once we do graduate. During my year at the BMJ, it has been a privilege to share the stories of countless students and doctors, and offer my platform to those who often remain unheard by policy makers. My theme for BMJ Student in 2024 is widening participation and diversity in medicine, and I will carry these passions into my work here in Morecambe Bay. I believe advocacy is an intrinsic part of the role of doctor, and to a lesser extent, of medical students. I carry these values and passions into my editorial work, but it is also a pleasure to spend my time working with and learning from the passions of my friends and colleagues. As true as it is that there is not one way for medical students to look or sound, it is equally true that there is no right answer to the question of what medical students care about. We rise by lifting others, and I cannot wait to see the dizzying heights that are to come for the Morecambe Bay Medical Journal.

## Digital Transformation Across the Bay

Janet Manning, Chief Nursing Information Officer, RN, DipHE, BSc (Honours), MSc

For a while now the University Hospitals of Morecambe Bay NHS Trust (UHMBT), along with the other trusts in the Integrated Care System (ICS), has been avidly waiting an announcement regarding the procurement of a new Electronic Patient Record (EPR) to replace the current Lorenzo system when the contract ends in July 2025. Unfortunately, for several reasons, the procurement has now been closed without appointing a supplier. The ICS plan moving forward is to review requirements to ensure that the contract will meet all the specifications of the trusts in the ICS and then invite suppliers to tender in 12 months' time. This ultimately means that there will be a significant delay in the implementation of a new system. When it does happen it will be an ICS wide transformation which will alter the way we manage the care of our patients using technology to help us. However, this cannot be seen as a digital project, it is so much more about transformation of our services and pathways. Digital technology is the enabler to support the fast-paced changes that are required to deliver patient care in a modern NHS.

Whilst the delay is frustrating to say the least, it does allow for us all to take our time to start the transformation work, to optimise our processes, pathways and streamline documentation. As the ambition is to share a single instance EPR across the ICS, there is a requirement for collaboration and agreement across all trusts as to how we care for our patients, using identified pathways supported by digital technology. For this to be successful, clinician support and engagement is vital as they are the main users of the systems. As transformation gets underway, clinician involvement will be required to shape the configuration of the new system; as who is better placed to understand what works well and where improvements are required?

Ms Sarah Hart, Integrated Care Board (ICB) EPR Clinical Lead, has commenced a pilot piece of work to understand how

shared cared pathways across the ICS can be created. This has provided some valuable insight as to who the stakeholders are and what role they will have in the transformation. It is clear that collaboration will be the key to success.

Effective use of clinician time is crucial to the provision of quality patient care, however, a heightened focus on the quality and detail needed for documentation has resulted in increasing pressure on the clinicians, staff dissatisfaction and burnout.<sup>1</sup> EPR's can improve workflow and reduce the burden if their implementation is optimised, with the support and engagement of the teams using them. If we passively accept a new system, it is likely that there will be dissatisfaction and increased burden, and that the system functionality will not be used optimally. A clinically driven transformation is paramount in the pre-implementation, go-live and stabilisation phases. This is supported by the KLAS survey of 2020 which suggests that user satisfaction is positively influenced by a thorough and clinically led implementation (see figure).<sup>2</sup>

Here in UHMBT, preparation for implementation of a new system is underway despite the pause in procurement. The EPR team are currently starting the work to pre-optimize the migration of information, data, and records by working initially with the Allied Health Professional teams to process map their use of electronic and paper systems in the current state. Unsurprisingly, there has been lots of duplication and unnecessary steps in process identified, which in general negatively impacts on the clinical teams. I am sure that colleagues across all disciplines would be able to identify similar scenarios in their own specialities and recognise the frustration that this can bring. This mapping exercise allows the Information, Informatics and Innovation (i3) team to work with the clinical teams to find solutions to these issues and improve our working lives and the experience of our patients for now and in the future state.