Finding the learning in clinical admin

Seemingly small “admin” tasks can have a huge bearing on a patient’s journey and experience, writes Anna Harvey Bluemel

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As the most junior doctor in the acute medical unit, each of my days starts in a similar way. I take a piece of off-white NHS paper, which has boxes and bed numbers already printed on it, and add patients’ names down the side. During the board round, I keep a careful track of the tasks that need to be completed for each patient. I use the classic box system—which is somehow passed down through generations of medics without anyone ever really explaining to you how it works—to keep track of my progress. Typical jobs include filling in referral forms, negotiating investigations with radiologists and endoscopists, taking blood and placing cannulae, and gathering collateral histories from relatives who are sadly still unable to accompany their loved ones into our ward.

My day to day work mostly consists of tasks that fall into the category of “admin.” A frequent complaint of junior doctors, especially foundation year 1 (FY1) doctors who don’t yet have their full GMC registration, is that too much of their time is spent doing these tasks and providing service, rather than being trained through clinical contact. Indeed, this is a longstanding concern internationally, with Forbes reporting in 2016 that doctors are “wasting two-thirds of their time doing paperwork.” I agree there is always a conversation to be had about ensuring training is fit for purpose and that it is allowing juniors to develop the skills they need to progress. Yet in reflecting on my first job as a junior doctor, I see these seemingly small “admin” tasks differently: as an opportunity to learn about myself and my approach to a clinical workload in a relatively controlled and supported environment.

Each morning, it’s up to me to prioritise the jobs I do. While senior doctors might emphasise certain tasks that particularly need to be completed as a matter of urgency, I am responsible for dictating how I conduct my working day to maximise the chances of the patients who are under my care being seen by the right people and investigated in the right way. Gaining experience in how to prioritise these “low stakes” (i.e. not immediately life or death) tasks gives junior doctors an opportunity to tentatively begin to manage their clinical workload. I have found that the more experience I had navigating the complexities of these daytime jobs, the more confident I felt in prioritising my time during on-call shifts, where there was often a higher level of clinical prioritisation required.

I have also come to value the learning I’ve gained from communicating with other members of the multidisciplinary team during these “admin” jobs. Take the quintessential task of phoning the on-call radiologist to discuss a request for a scan. You feel under great pressure to secure this scan and are nervous. But after the first few times, you learn to anticipate the questions you may be asked, and eventually come to the conversation armed with all the information you might need to secure the scan. These interactions not only teach you about professional communication, they allow us as very junior doctors to explore our clinical “personalities” in how we approach interactions that have the potential to be challenging. Ultimately, this experience of clinical communication is valuable; when it comes to discussing important clinical handovers—say, about a deteriorating patient on a night shift—you are able to go into the conversation with the confidence that you have all the information you might need. The new experience of taking handovers from nursing staff has also been a great lesson in what a useful handover actually looks (or sounds) like and has helped me adjust my own accordingly.

Similarly, having what might be considered “low stakes” information gathering conversations with patients and/or their relatives teaches junior doctors vital communication skills that will be useful as we become more senior, when more emotionally charged conversations (such as end of life or do not attempt cardiopulmonary resuscitation discussions) may be demanded of us. The ability to develop a rapport with a patient as a doctor, not just a medical student, is subtly different due to the new responsibilities that the title of doctor confers in the clinical environment. Patients and relatives have different expectations of doctors than they do of students. Learning to manage these expectations, explain clinical processes using appropriate language, and gather information quickly during these interactions with patients and relatives all add to your body of experience, which can be drawn upon when the time comes in your career to have more complex discussions.

Finally, the much maligned discharge summary: yes, creating these documents can be time consuming. It can also be frustrating to synthesise all the important touchpoints of a patient’s hospital stay in a succinct narrative, with the competing audiences of other clinicians, both in primary and secondary care, and patients (and potentially relatives). But as the completer of this document, the junior doctor serves an important purpose: they are the conduit between different aspects of care, providing the link between primary and secondary care. The person writing the discharge summary may also be the only healthcare professional to look at a patient’s entire journey, from admission to discharge, giving them the power to link together all the events that have led to a patient’s
hopefully successful return home. Perhaps it is the former journalist in me that finds such satisfaction in the crafting of a discharge letter, but every time I write one I feel I learn something about the assessment, diagnosis, and management of often very complex patients. I might actually add little to these patients’ care due to my lack of knowledge and experience at this point in my career, but I can continue to learn from and help them (in the background) by charting their hospital journey in simple terms that will continue to serve them once they are discharged.

In my experience, your FY1 year is not simply a rite of passage, or a job to be done because “someone has to do it, and you only have to do it for a year” (as one of my consultants so succinctly put it). These admin tasks, so often the domain of the most junior member of the team, are the grease on the wheels of the NHS and they have a huge bearing on a patient’s journey and experience. Alongside this, managing your own workload of these sometimes seemingly disparate, isolated tasks sets the blueprint for how you approach a clinical workload throughout your career; communicate with other healthcare professionals, patients, and relatives; and begin to lead a team. So to my fellow FY1s: I see your beautifully filled in referral forms, your deft handling of a tricky collateral history over the phone, that time you got the radiologist to approve a scan that led to a diagnosis. Enjoy the small victories—you’re doing a great job.

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