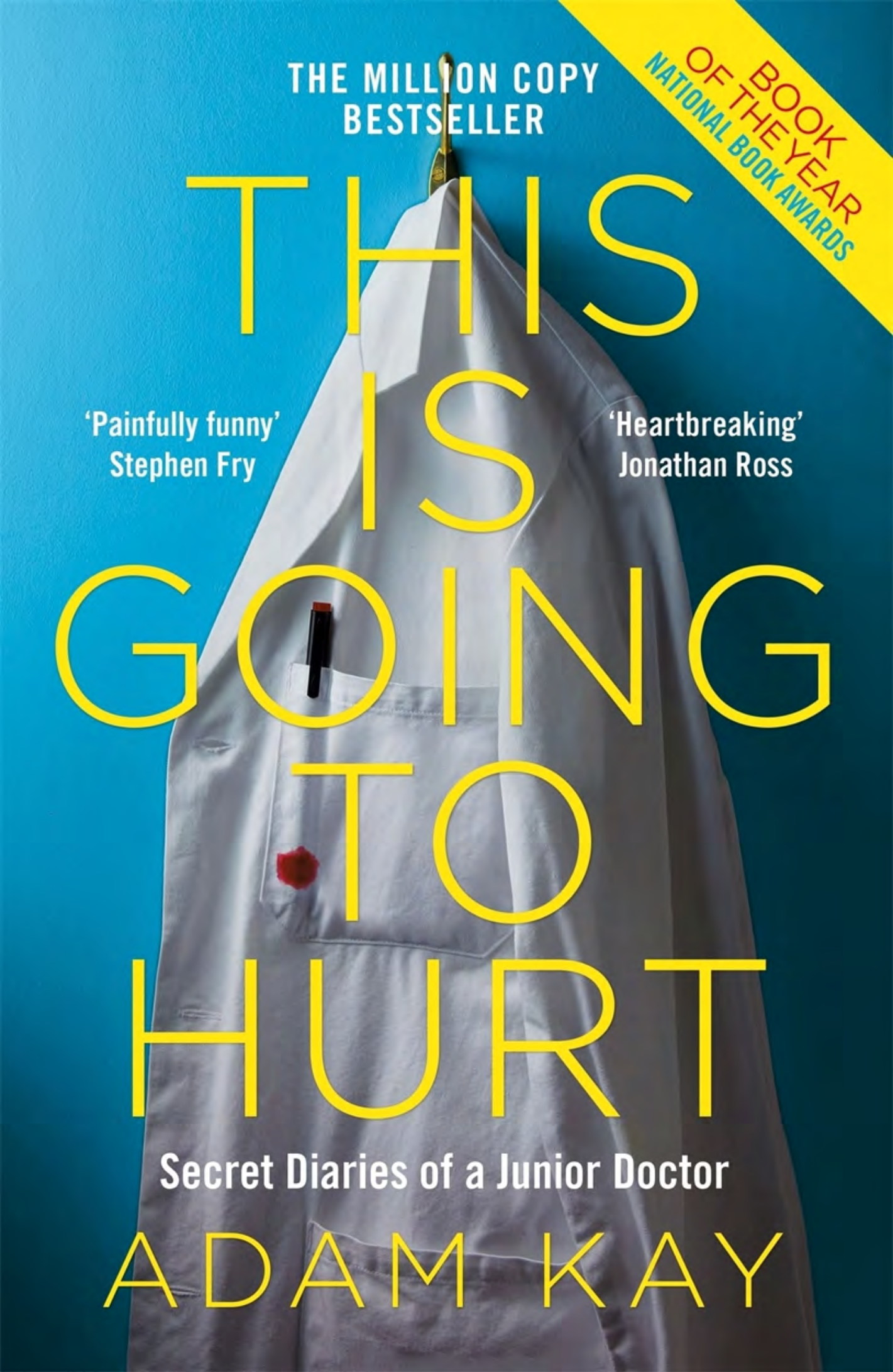
THE MILLION COPY BESTSELLER
BOOK OF THE YEAR
NATIONAL BOOK AWARDS
'Painfully funny'
Stephen Fry
'Heartbreaking'
Jonathan Ross
THIS IS GOING TO HURT
Secret Diaries of a Junior Doctor
ADAM KAY

1

House Officer

The decision to work in medicine is basically a version of the email you get in early October asking you to choose your menu options for the work Christmas party. No doubt you'll choose the chicken, to be on the safe side, and it's more than likely everything will be all right. But what if someone shares a ghastly factory farming video on Facebook the day before and you inadvertently witness a mass debeaking? What if Morrissey dies in November and, out of respect for him, you turn your back on a lifestyle thus far devoted almost exclusively to consuming meat? What if you develop a life-threatening allergy to escalopes? Ultimately, no one knows what they'll fancy for dinner in sixty dinners' time.

Every doctor makes their career choice aged sixteen, two years before they're legally allowed to text a photo of their own genitals. When you sit down and pick your A levels, you're set off on a trajectory that continues until you either retire or die and, unlike your work Christmas party, Janet from procurement won't swap your chicken for her halloumi skewers – you're stuck with it.

At sixteen, your reasons for wanting to pursue a

career in medicine are generally along the lines of 'My mum/dad's a doctor', 'I quite like *Holby City*' or 'I want to cure cancer'. Reasons one and two are ludicrous, and reason three would be perfectly fine – if a little earnest – were it not for the fact that's what research scientists do, not doctors. Besides, holding anyone to their word at that age seems a bit unfair, on a par with declaring the 'I want to be an astronaut' painting you did aged five a legally binding document.

Personally, I don't remember medicine ever being an active career decision, more just the default setting for my life – the marimba ringtone, the stock photo of a mountain range as your computer background. I grew up in a Jewish family (although they were mostly in it for the food); went to the kind of school that's essentially a sausage factory designed to churn out medics, lawyers and cabinet members; and my dad was a doctor. It was written on the walls.

Because medical schools are oversubscribed ten-fold, all candidates must be interviewed, with only those who perform best under a grilling being awarded a place. It's assumed all applicants are on course for straight As at A level, so universities base their decisions on non-academic criteria. This, of course, makes sense: a doctor must be psychologically fit for the job – able to make decisions under a terrifying amount of pressure, able to break bad news to anguished relatives, able to deal with death on a daily basis. They must have something that cannot be memorized and graded: a great doctor must

have a huge heart and a distended aorta through which pumps a vast lake of compassion and human kindness.

At least, that's what you'd think. In reality, medical schools don't give the shiniest shit about any of that. They don't even check you're OK with the sight of blood. Instead, they fixate on extracurricular activities. Their ideal student is captain of two sports teams, the county swimming champion, leader of the youth orchestra and editor of the school newspaper. It's basically a Miss Congeniality contest without the sash. Look at the Wikipedia entry for any famous doctor, and you'll see: 'He proved himself an accomplished rugby player in youth leagues. He excelled as a distance runner and in his final year at school was vice-captain of the athletics team.' This particular description is of a certain Dr H. Shipman, so perhaps it's not a rock-solid system.

Imperial College in London were satisfied that my distinctions in grade eight piano and saxophone, alongside some half-arsed theatre reviews for the school magazine, qualified me perfectly for life on the wards, and so in 1998 I packed my bags and embarked upon the treacherous six-mile journey from Dulwich to South Kensington.

As you might imagine, learning every single aspect of the human body's anatomy and physiology, plus each possible way it can malfunction, is a fairly gargantuan undertaking. But the buzz of knowing I was going to become a doctor one day – such a big deal you get to literally change your name, like a superhero or an

international criminal – propelled me towards my goal through those six long years.

Then there I was, a junior doctor.* I could have gone on *Mastermind* with the specialist subject 'the human body'. Everyone at home would be yelling at their TVs that the subject I'd chosen was too vast and wide-ranging, that I should have gone for something like 'atherosclerosis' or 'bunions', but they'd have been wrong. I'd have nailed it.

It was finally time to step out onto the ward armed with all this exhaustive knowledge and turn theory into practice. My spring couldn't have been coiled any tighter. So it came as quite the blow to discover that I'd spent a quarter of my life at medical school and it hadn't remotely prepared me for the Jekyll and Hyde existence of a house officer.†

During the day, the job was manageable, if mind-numbing and insanely time-consuming. You turn up every morning for the 'ward round', where your whole

---

* 'Junior doctor' refers to anyone who isn't a consultant. It's a bit confusing as a lot of these 'junior doctors' are actually pretty senior – some have been working for fifteen years, picking up PhDs and various other postgraduate qualifications. It's a bit like calling everyone in Westminster apart from the prime minister a 'junior politician'.

† The hierarchy goes: house officer, senior house officer (SHO), registrar, senior registrar, consultant. They've recently renamed the ranks: it's now F1, F2, ST1–7. Everyone still uses the old terminology though, like when Coco Pops were briefly rebranded as Choco Krispies.

team of doctors pootles past each of their patients. You trail behind like a hypnotized duckling, your head cocked to one side in a caring manner, noting down every pronouncement from your seniors – book an MRI, refer to rheumatology, arrange an ECG. Then you spend the rest of your working day (plus generally a further unpaid four hours) completing these dozens, sometimes hundreds of tasks – filling in forms, making phone calls. Essentially, you're a glorified PA. Not really what I'd trained so hard for, but whatever.

The night shifts, on the other hand, made Dante look like Disney – an unrelenting nightmare that made me regret ever thinking my education was being under-utilized. At night, the house officer is given a little paging device affectionately called a bleep and responsibility for every patient in the hospital. The fucking lot of them. The night-time SHO and registrar will be down in A&E reviewing and admitting patients while you're up on the wards, sailing the ship alone. A ship that's enormous, and on fire, and that no one has really taught you how to sail. You've been trained how to examine a patient's cardiovascular system, you know the physiology of the coronary vasculature, but even when you can recognize every sign and symptom of a heart attack, it's very different to actually managing one for the first time.

You're bleeped by ward after ward, nurse after nurse with emergency after emergency – it never stops, all night long. Your senior colleagues are seeing patients in A&E with a specific problem, like pneumonia or a broken

leg. Your patients are having similar emergencies, but they're hospital inpatients, meaning they already had something significantly wrong with them in the first place. It's a 'build your own burger' of symptoms layered on conditions layered on diseases: you see a patient with pneumonia who was admitted with liver failure, or a patient who's broken their leg falling out of bed after another epileptic fit. You're a one-man, mobile, essentially untrained A&E department, getting drenched in bodily fluids (not even the fun kind), reviewing an endless stream of worryingly sick patients who, twelve hours earlier, had an entire team of doctors caring for them. You suddenly long for the sixteen-hour admin sessions. (Or, ideally, some kind of compromise job, that's neither massively beyond nor beneath your abilities.)

It's sink or swim, and you have to learn how to swim because otherwise a ton of patients sink with you. I actually found it all perversely exhilarating. Sure it was hard work, sure the hours were bordering on inhumane and sure I saw things that have scarred my retinas to this day, but I was a doctor now.

Tuesday, 3 August 2004

Day one. H* has made me a packed lunch. I have a new stethoscope,† a new shirt and a new email address: atom.kay@nhs.net. It's good to know that no matter what happens today, nobody could accuse me of being the most incompetent person in the hospital. And even if I am, I can blame it on Atom.

I'm enjoying the ice-breaking potential of the story, but in the pub afterwards, my anecdote is rather trumped by my friend Amanda. Amanda's surname is Saunders-Vest. They have spelled out the hyphen in her name, making her amanda.saundershyphenvest@nhs.net.

Wednesday, 18 August 2004

Patient OM is a seventy-year-old retired heating engineer from Stoke-on-Trent. But tonight, Matthew, he's going to be an eccentric German professor with ze unconvinzing agzent. Not just tonight in fact, but this morning, this afternoon and every day of his admission;

---

* H is my short-suffering partner of six months. Don't worry – you're not going to have to remember huge numbers of characters. It's not *Game of Thrones*.

† I'm all for explaining terminology as we go along, but if you don't know what a stethoscope is, this is probably a book to regift.

thanks to his dementia, exacerbated by a urinary tract infection.*

Prof OM's favourite routine is to follow behind the ward round, his hospital gown on back-to-front, like a white coat (plus or minus underwear, for a bit of morning Bratwurst), and chip in with 'Yes!', 'Zat is correct!' and the occasional 'Genius!' whenever a doctor says something.

On consultant and registrar ward rounds, I escort him back to his bed immediately and make sure the nursing staff keep him tucked in for a couple of hours. On my solo rounds, I let him tag along for a bit. I don't particularly know what I'm doing, and I don't have vast depths of confidence even when I do, so it's actually quite helpful to have a superannuated German cheerleader behind me shouting out, 'Zat is brilliant!' every so often.

Today he took a dump on the floor next to me so I sadly had to retire him from active duty.

Monday, 30 August 2004

Whatever we lack in free time, we more than make up for in stories about patients. Today in the mess† over

---

* In the elderly, urinary tract infections, or any kind of low-grade sepsis, often make them go a bit nuts.

† The 'doctors' mess' either refers to our communal area with a few sofas and a knackered pool table or the state of most of my patients in the first few months.

lunch we're trading stories about nonsense 'symptoms' that people have presented with. Between us in the last few weeks we've seen patients with itchy teeth, sudden *improvement* in hearing and arm pain during urination. Each one gets a polite ripple of laughter, like a local dignitary's speech at a graduation ceremony. We go round the table sharing our version of campfire ghost stories until it's Seamus's turn. He tells us he saw someone in A&E this morning who thought they were only sweating from half of their face.

He sits back in anticipation of bringing the house down, but there's merely silence. Until pretty much everyone chimes in with: 'So, Horner's syndrome then?' He's never heard of it, specifically not the fact that it likely indicates a lung tumour. Seamus scrapes his chair back with an ear-splitting screech and dashes off to make a phone call to get the patient back to the department. I finish his Twix.

Friday, 10 September 2004

I notice that every patient on the ward has a pulse of 60 recorded in their observation chart so I surreptitiously inspect the healthcare assistant's measurement technique. He feels the patient's pulse, looks at his watch and meticulously counts the number of seconds per minute.