# PROLOGUE

A red dirt road steeped in red dawn light and the faintest mutter of guns. The first refugees, hazy in the distance, slowly bearing down on the town. Women and children leading the retreat, bin bags and mattresses balanced upon heads, babies swaddled tight to adult hips. They crossed a façade of buildings peppered with bullet holes, impassive and mute, looking past us. My cameraman and I couldn't believe our luck. The juxtaposition of gentle morning light with the ugliness of war – it was television gold, and we knew it.

Before I became a doctor, I turned people's lives into films for a living. I was a journalist, producing and directing current-affairs documentaries like this one about the civil war in the Democratic Republic of Congo. It was 2003. The conflict, described by Prime Minister Tony Blair as 'a scar on the conscience of the world', had already claimed 5 million lives, most of which were civilian. Bunia, the battered town

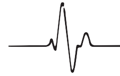
into which we'd flown a few days earlier, was widely regarded as the heart of the slaughter. Rape and brutalities were commonplace. Only a month before our arrival, five hundred townsfolk had been butchered by militiamen armed with machetes. The town's makeshift, tented hospital was still filled with amputees, the youngest of whom was seven.

Even as the pace of the displaced began to quicken, and the rumble of guns grew more insistent, I couldn't resist keeping the camera rolling. The crowd began to jog and then to scatter. Bedding and possessions were dumped in the dust, children started to wail. Defeated militiamen now joined the civilians, armed with AK-47s, yet in flight and disarray. As the army from which they fled finally burst through the trees, all at once we came under their incoming fire. The air hummed with bullets. We stampeded for the only safe place in town: the United Nations peacekeepers' compound with six thousand refugees already crammed behind its razor wire.

Inside the UN building, twenty or so journalists now cowered on a concrete floor as gunfire raged around us. Every grenade made the walls shake. We prayed they didn't have mortars. I was certain I'd be raped, then cut to pieces. I wished I knew nothing about Bunian militiamen's preferred modalities of killing. I wondered if the man from Agence France-Presse against whom I was crushed would mind if I held his hand for a moment. I longed to call my parents to tell them that I loved them. Our cameras never stopped rolling.

After four interminable hours, the gunfire finally abated. Casualties now besieged the town's rudimentary hospital. The UN's tented city had swollen by another few hundred refugees. We'd gratefully escaped our concrete bunker but, with night falling and distant guns still rumbling, we

had absolutely nowhere safe to go. Every street in town was overrun with militia, so we begged the protection of UN peacekeepers' guns. I lay all night on a plastic sheet beneath the compound's walls, clutching my mosquito net, too scared to close my eyes. Years later, our footage would help successfully prosecute a Congolese warlord in the UN International Criminal Court. But, at the time, filming in Bunia felt less like an achievement than an act of monumental stupidity. I'd been out of my depth, flying blind.



At age twenty-nine, I left my career in television journalism to retrain as a doctor. On swapping current affairs for a caring profession, I imagined I'd put war zones behind me. Yet ironically – given that hospitals are meant to be citadels of healing – the most frightening experience of my professional life was not those hours spent under fire in Congo's killing fields but my first night on call in a UK teaching hospital. Had anyone predicted this at the time, I'd have laughed at their hyperbole. But nothing, it turned out, quite matched for me the terror of being spat out of medical school into a world of blood, pain, distress and dying that I believed I must expertly navigate, while feeling wholly ill-equipped to do so.

My first set of nights loomed like a prison sentence. As a newly minted doctor, I knew twenty-eight causes of pancreatitis, the names of all two hundred and six bones in the human body, the neurophysiology of stress and fear, but not – not even remotely – how to make the emergency decisions that, if I got them wrong, might end up being the death of someone. No one had taught me what to *do* with all my knowledge. I wasn't even sure I could correctly pick

out the sick patients from the ones I didn't need to worry about. And yet, in dimly lit wards across the hospital at night, several hundred patients' lives were about to rest, at least initially, in my inexpert hands. I felt like a white-coated fraud.

In an effort to manage my imposter syndrome, I prepared for my nights like a military campaign. My Royal Air Force fighter-pilot husband – a man for whom aerial dogfights in a Tornado F3 barely even quickened the heart rate – advised me that the key, at all costs, was to 'stay frosty'. In a forlorn effort to acquire Dave's elusive inner frostiness, I retreated to what I knew: my textbooks, revising how to manage every life-or-death emergency I could possibly think of until – in my head at least – I was handling them all like George Clooney. I stocked up on Diet Coke, cashew nuts and morale-boosting chocolate bars. I snuck a pocket guide to emergency medicine into the bottom of my rucksack and chose sensible shoes for sprinting to crash calls. And, when I arrived at my first ever hospital handover at 9 p.m., I took custody of my on-call bleep – the electronic pager through which the nurses would spend the night contacting me – with what I hoped looked like battle-weary nonchalance, while secretly wanting to vomit.

The departing house officer handed me a barely legible list of jobs – patients needing cannulas placed in their veins, blood tests or urinary catheters – before fleeing into the night. The medical registrar, the senior doctor to whom I was meant to turn for help should I find myself out of my depth, told me in no uncertain terms that he'd be busy all night in A&E, but to bleep him if I absolutely had to. The other doctors dispersed, all looking grimly competent.

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Bleep. It started. Nurses calling me about the patients on their wards with racing hearts, plummeting blood pressure or worryingly low levels of oxygen. Bleep. They all wanted me to come immediately to assess their patients. But, even as I tried to answer the first bleep, the second and third were lighting up my pager.

'For God's sake,' I wanted to tell them, 'will you please bleep somebody else, because I'm not a doctor, not even remotely?'

There was, of course, nobody else. I was alone at the start of my shift, wanting to cry, with a jobs list already covering two pages.

Mr Frith was one of the first patients I reviewed that night. All his numbers, rattled off by a nurse on the end of a phone, were bad. Heart too fast, blood pressure too low, oxygen levels barely compatible with consciousness. Even I knew enough to rush straight to his bedside. He lay alone in the semi-darkness – eyes rolling wildly, breaths coming in short fitful gasps, lips clearly blue – trying to communicate in fractured monosyllables. A retired linguist in his early seventies, he had been admitted to hospital some ten days previously with a mild heart attack that had been complicated by a pneumonia picked up in hospital. All this was eminently reversible. There was no reason why he should not be able to return safely home to his wife of forty years. But, right now, he looked deathly. His nurse was nowhere to be seen.

I was certain that something was terribly wrong, despite not being able to name it. The sounds in his chest, magnified by my stethoscope, were like nothing I had heard before. A grinding and rattling more mechanical than human, ugly and wrong. I guessed that Mr Frith's heart was failing, causing

fluid to swamp and overwhelm his lungs. If I was right, he was drowning before my eyes.

Sick with dread, I fumbled to put an oxygen mask over his stubble and ran to the nurses' station to try to find his nurse.

'Who's looking after Mr Frith, please?' I asked the three nurses sitting behind the desk.

'Who?' said one of them. 'Frith? Oh, you mean Bed 4. Miriam. She's on a break.'

'Well – please could you help me?' I asked, far too hesitantly.

'No. He's not my patient.'

'I – I think I need help.'

'Well, you need to call your boss, then, don't you?'

So I did. I did not know what else to do. I bleeped the registrar once, twice, multiple times. But my calls to his bleep went unanswered. I had no nurse, no senior doctor to help me, and a patient on the brink of death. In sheer desperation, I ran down seven flights of stairs to the Emergency Department to try to physically manhandle my missing senior doctor up to my patient's bedside. It was precisely at that moment, while I was frantically scouring A&E for help, that Mr Frith's heart stopped beating.

Everything I did that night was wrong, starting with my pitiful meekness. There is a code no one teaches you at medical school, a certain way of getting things done. When you find a patient *in extremis*, for example, you shout as loudly as you can from the bedside, 'I need some help, please' and four of five staff will instantly materialise. Better yet – it is not rocket science – you simply press the red emergency button beside every patient's bed and a wardful of staff will rush to your aid. Most effectively, if you think your patient

is 'peri-arrest' – on the brink of suffering a cardiac arrest – you put out a crash call via the hospital switchboard and in moments a crack squad of resuscitation experts should rally to the bedside.

I violated the code. I was timid and polite when I should have been assertive. I gave the nurses none of the right cues, and I lacked the practical knowledge that a crash call is appropriate for anyone you think is about to fall off a cliff, not only those who have already done so. Perhaps it is the fear of being seen to do the wrong thing – the embarrassment of mistaking a patient's minor unwellness for a full-blown emergency – that holds young doctors back from calling the cavalry. This reticence has the potential to cost patients their lives.

That night, when the crash call came, I was the most junior member of the crash team, and also the farthest away from Mr Frith's bedside. I was still in A&E, searching in vain for my registrar. The four shrill bleeps that herald an arrest call are deliberately designed to stop you in your tracks, focusing your attention on the crackling, barely audible telephonist's voice instructing you where to assemble.

'Adult arrest call. Adult arrest call. Adult crash team to Level 7. I repeat, Level 7.'

In this case, I already knew exactly where to head. With sick clarity, I confronted the fact that I had physically abandoned my patient just before his heart has stopped beating. Horrified, wishing it were anyone but him, I ran back up the seven flights of stairs just in time to hear the consultant leading the team ask, 'Who the hell is this "Clarke" who last saw the patient?'

'It was me,' I muttered, barely audibly, as all eyes turned on me.

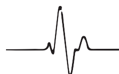
My entry in the patient's notes, now in the hands of the consultant, was hastily scrawled and abruptly curtailed by my panicked departure. It must have looked woefully inadequate.

'I'm sorry,' I whispered, burning with shame. 'I didn't know what to do. I went to get help.'

The registrar who had failed to answer my bleeps stood silently beside the consultant, eyeballing me defiantly. I did not dare mention his involvement – or, rather, the lack of it.

Mr Frith had been submerged beneath wires, tubes and defibrillator leads. The team had already given intravenous drugs to take the pressure off the heart and lungs. The chest compressions were brutal but effective and the first electric shock brought his heart leaping back into a normal rhythm. He started to pink up and open his eyes, blooming back to life. I wanted to weep with relief and gratitude. It was slick, textbook, a rare perfect crash call – except for the fact, so it seemed to me, that, had a better doctor done a better job earlier, it might have been entirely preventable.

As the team busied themselves transferring Mr Frith to the intensive care unit, I had never felt more incompetent. The shame and guilt made me want to quit medicine, barely before I'd begun.



Britain's junior doctors are often described by politicians as the 'backbone of the NHS', the workhorses whose slog – alongside that of the nurses, paramedics and all the other allied health professionals hard at work on the front line – keeps the NHS alive. But our first steps onto a hospital ward, heads typically crammed with facts but little life experience,

can be steeped in isolation and hidden fears. In a profession that should be defined by compassion, growing a backbone can be brutal.

Perhaps in medicine there is no way to avoid toughening up the hard way, through repeated exposure to life-or-death situations until your skills, expertise and the thickness of your skin can finally, just about, handle them. But what if this process takes place in a health service so overstretched and understaffed that its doctors, along with everyone else, feel they are routinely scrabbling against impossible odds merely to keep their patients safe, let alone dispense compassion and exemplary care? So that – even if a young doctor has acquired the experience to handle anything medicine can throw at them – they feel increasingly paralysed as a practitioner by a system that is crumbling and being rationed around them?

In 2016, these questions were thrown into sharp relief by the dispute between junior doctors and the government over our terms and conditions of work. The conflict mobilised thousands of medics like me out on strike when we should have been looking after our patients. It ignited a war of words so toxic between government and doctors that their corrosive legacy will take years to repair. It drove many doctors, some of them my friends, to quit the NHS in unprecedented numbers. And ultimately, after months of conflict, it led to what were perhaps the saddest two days in NHS history: the country's first ever all-out doctors' strike, with complete withdrawal of junior doctor care. There were no winners during the junior doctor saga, yet no one lost as much as our patients.

Throughout the dispute, according to government press officers, the rage, upheaval and bitterness centred on one issue alone: junior doctors' refusal to give up their Saturday

overtime. Our intractability made it impossible, they claimed, for former Prime Minister David Cameron to deliver on his general-election pledge to give the electorate a 'truly seven-day NHS'. And the stakes could not have been higher. According to the Secretary of State for Health, Jeremy Hunt, every year in the UK eleven thousand people were losing their lives unnecessarily because too few doctors worked at the weekend.

Hunt's line was powerful, emotive stuff. While the doctor in me flinched at each insinuation, my journalistic self recognised a shrewd and effective political strategy. I'd learned about spin from the best. Some eighteen years earlier, as a fresh-faced TV researcher on Jonathan Dimbleby's ITV politics show, I'd helped construct the interviews that Labour's shrewdest spin doctors, Alastair Campbell and Peter Mandelson, had done their utmost to control. We interviewed Tony Blair a week or so before his 1997 general election victory. I remember sitting hunched on the floor over a tiny screen, jotting down soundbites to use in our ad break, when a presence loomed above me. 'I wouldn't bother wasting time on that,' Campbell said, grinning mirthlessly. 'Your boy won't get anything from mine.' He was absolutely right. We didn't.

Using fear to build political capital is a tactic as old as politics. All that was new on this occasion was the target – not foreigners, immigrants, scroungers or Muslims, but the medical profession itself. In 2015, the new majority Conservative government, unshackled at last from its Liberal Democrat coalition partners, had the NHS medical wage bill in its sights. Junior doctors, consultants and general practitioners all faced a renegotiation of their contracts and

– perhaps assuming 'junior' meant weak – Jeremy Hunt had decided to press ahead initially with ours.

The strategy was simple. First, put the fear of God into people by claiming that eleven thousand patients will die annually at weekends because doctors are too lazy or greedy to work them. Next, allay the fears you've just stoked so meticulously by promising the solution: the seven-day services the country currently lacks. Finally – and most audaciously of all – insist that a 'cost-neutral' renegotiation of the junior doctor contract will deliver said seven-day NHS. The small matter of more staff and more funds being an obvious prerequisite for improved front-line services was conveniently omitted from the government's narrative. Junior doctors, not the Treasury, were the barrier to safe weekends.

When the dispute began, I had been a journalist for ten years and a hospital doctor for another six, long enough to evolve from nervous ward ingénue into an experienced and valued member of my hospital's front line. Year on year, I had witnessed the human impact of funding cuts: patients waiting longer and longer for treatment, doctors quietly disappearing from the rotas as recruitment became ever more problematic. Still, my spirits were high. With six years of medicine and numerous postgraduate exams under my belt, I was ready and eager to embark upon my chosen speciality of palliative care. The distressing, sometimes haunting, challenges of helping patients at the end of life to live as fully and richly as possible had touched something deep within me. Not once had I ever predicted junior doctors being targeted by the Number 10 spin machine, or how destructive and demoralising Downing Street's crosshairs would be.

Through the dual perspectives of doctor and journalist, I

would look on, aghast, as the government ran rings round the doctors' trade union, the British Medical Association (BMA). But what was it really about? Beneath the slews of accusation and recrimination, what actually drove a generation of young doctors to abandon their patients and go out on strike? Even Jeremy Hunt could not in all seriousness have believed we did it merely to preserve our Saturday pay rates. This was a complex, nuanced dispute in which concerns surrounding pay, patient safety, staffing levels and morale were inextricably linked. Even the phrase 'junior doctor' glossed over the huge variety of individuals who were doctors in training, ranging from single twenty-three-year-olds, fresh out of medical school, to mothers and fathers in their late thirties or forties, experienced doctors on the brink of becoming specialist consultants.

For me, the junior doctor dispute – a pivotal moment in NHS history – was deeply embedded in the wider health of the modern NHS. Strikes were drastic, a last resort. This was the first time that young doctors had abandoned their patients in over forty years, and we would do so on eight different days. Fundamentally, going on strike, for the majority of us, was an act of desperation born out of our lived experience of the NHS front line. Ours is a supremely under-doctored health service. There is simply not the money to employ enough doctors. Statistics from the Organisation for Economic Cooperation and Development (OECD) show we have only 2.8 practising doctors per 1,000 heads of population, fewer than almost any country in Europe, including Poland, Latvia and Lithuania. In Germany, by contrast, that figure is 4.1 doctors, and in Greece it is 6.3 doctors.[1]

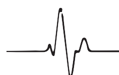
What that translates into for a junior doctor is under-

staffing that is at best exhausting, at worst soul-destroying. I can't count the number of times I've been left to shoulder two doctors' jobs when there's a gap – a missing doctor – in my junior doctor rota. Those 'rota gap' shifts are grim, thankless exercises in firefighting, and they are becoming increasingly prevalent. When I first qualified in 2009, they were mercifully rare, but these days they feel like the norm. We dread them and, perhaps more pertinently, so should our patients. Because, no matter how finely honed a doctor's acute resuscitation skills, we cannot be in two places at once. When understaffing has forced one doctor to carry two doctors' crash bleeps, the risks of a patient slipping through the cracks have clearly just doubled: too few doctors threatens lives.

A further casualty of doctor overstretch is the one that compelled us into medicine in the first place – and the one we can least afford to lose – our kindness. People say the NHS runs only on the goodwill of its staff: the doctors, nurses and allied healthcare professionals who are willing to go the extra mile not for money, or thanks, or praise, or self-promotion, but for the intrinsic rewards of helping a patient. If that's right, then working conditions that grind away relentlessly at our capacity for kindness threaten the survival of the NHS itself. More immediately, they are the enemy of the doctor–patient relationship. When doctors are too few on the ground, when you haven't a chance of managing your workload in the time you are meant to be at work, then every precious second is spent scrabbling merely to keep your patients safe. Talking to patients and their relatives is inevitably left until last. The humanity of a conversation has become a luxury your conditions of work deny. Doctors are turned into hardened machines, patients are left in the dark. You know it's wrong,

you hate what you've become, and now perhaps you consider quitting the profession you once loved with all your soul.

We've already reached this point. The question that led me, heavy-hearted, full of doubt, to the picket lines in 2016 was not 'How can I protect my Saturday overtime?' but, 'How can I continue to conduct myself with compassion and humanity in an NHS that is falling apart?' Like so many of my fellow junior doctors, I knew I had nothing more to give. A contract that stretched us even more sparsely across seven days, not five, would, I had no doubt, be the breaking of me.



This is a book about working within the institution in which I was born, gave birth and will probably die, provided it still exists then. An NHS doctor saved the life of my newborn son and, as I write, an NHS oncology team is attempting to prevent cancer from taking the life of my father. Like so many other families in Britain, the members of mine have experienced some of the most joyous, momentous, harrowing and moving moments of our lives within Britain's National Health Service. And, like so many other NHS doctors, nurses, midwives, porters, physiotherapists, radiographers, pharmacists and dieticians, when it comes to the institution I professionally serve, I am unashamedly partisan. That we are willing, collectively, to pay sufficient tax to ensure no one is denied the healthcare they need because they cannot afford it makes me feel genuinely proud to be British. And providing my patients with cradle-to-grave NHS care based on that clinical need, not ability to pay, is my absolute joy and privilege.

Every day, I bear witness to ordinary NHS staff going about

their extraordinary work – dressing the wounds, breaking the bad news, holding the hands, wiping the excrement, restarting the stalled hearts, smoothing the eyelids of the newly dead – with the utmost compassion and care. I love my job. I could not imagine a more rewarding and fulfilling career than medicine. But I am afraid we may have reached the point at which the NHS's greatest asset – its staff – has become terminally exhausted. The goodwill and kindness without which the NHS will not survive are being inexorably squeezed out by underfunding, understaffing and the ever more unrealistic demands placed upon a floundering workforce. This is the untold story of the challenges of trying to stay kind while practising on an overstretched NHS front line.