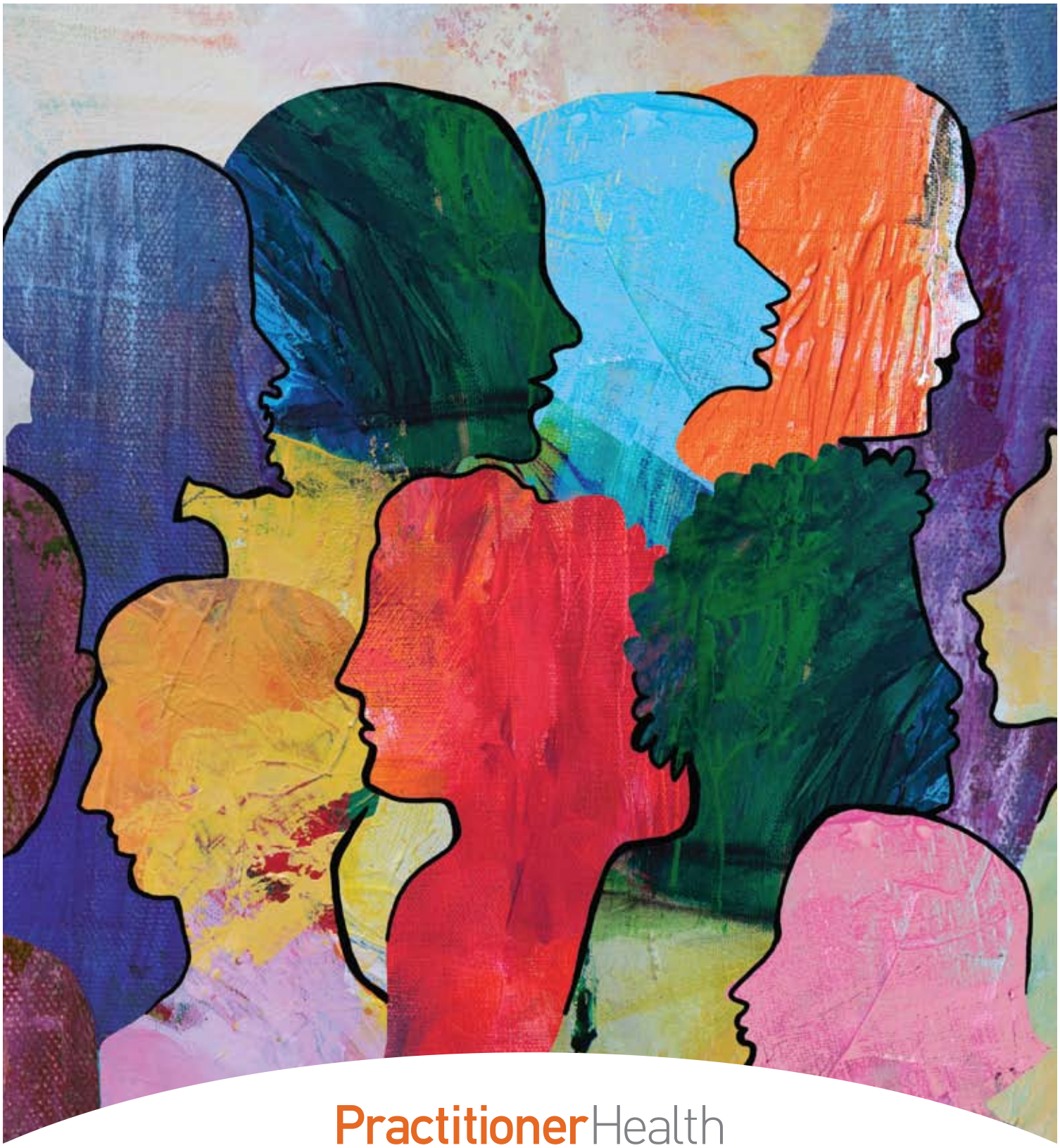


PractitionerHealth

LOOKING AFTER YOUR WELLBEING IN CONFIDENCE

ANNUAL REPORT

2023

CHAIRMAN'S REPORT

Professor Frank Murray - Chairman Practitioner Health

Dear Colleagues,

As Chairman of the Board of Practitioner Health, I am pleased to present our 2023 Annual Report. The enthusiastic commitment of Practitioner Health continues with an increase in numbers of practitioners presenting to the service again this year.

The importance of having a confidential, independent programme is evident and we are pleased to be able to offer such a service to our colleagues. We recognise that seeking help can be difficult for a practitioner, with many barriers preventing easy access to support. Our aim is to be accessible in a timely manner when someone contacts the programme, recognising that practitioners often present late and sometimes in crisis.

Practitioner Health is a registered charity and is fully complaint with the Charity Regulator requirements and with audited annual accounts. We are indebted to all our donors who continue to provide crucial financial support to the programme. This enables us to sustain the programme in its current format.

I would like to acknowledge and express my thanks to the outstanding commitment and skills of the Practitioner Health team delivering the service, so ably led by Dr Íde Delargy in her role as Medical Director.

Professor Frank Murray MD
Chairman, Practitioner Health

MEDICAL DIRECTOR'S REPORT

Dr Íde Delargy - Medical Director Practitioner Health

I am pleased to report on the work of Practitioner Health (PH) for 2023. The programme continues to expand and we believe that there is an increasing awareness of the work we do and how to access our support. We are particularly aware that practitioners often present late and sometimes in crisis. We therefore aim to respond as quickly as possible and to arrange to see patients in a timely manner.

Practitioners may struggle for a variety of reasons. Sometimes it relates to unaddressed underlying vulnerabilities or stressors in their personal lives. What we do know is that the demands and responsibility of the job they do can be a precipitant for acute anxiety, depression or burnout. Many try to conceal their distress and continue to wear the "mask" of normality by continuing to work. The link between physician health and wellbeing to patient outcomes is well documented and therefore all efforts need to be made to ensure our practitioners get help when needed and are supported in being healthy and well. Practitioners worry about confidentiality particularly if they are suffering with a mental health or substance use disorder. The confidentiality aspect of Practitioner Health is a key component and offers a safe place for someone to share their vulnerabilities and get the help required to return to full health again. We pride ourselves on being a service that is compassionate, non-judgmental and practical which practitioners really appreciate.

I would like to take this opportunity to thank my colleague Dr Justin Brophy who has been such an excellent clinician and a wonderful support to me in this work over many years. I would also like to acknowledge the work of Dr Caragh Behan and Dr Matt Lynch who have more recently joined our clinical team.

I would like to give a special mention to our excellent Board of Trustees who steer the Practitioner Health programme with passion and prudence. I am indebted to their ongoing work and without the commitment, expertise and the support of this dedicated Board, the programme would not be as successful as it is.

Dr Íde Delargy
Medical Director, PHMP

MISSION STATEMENT

Practitioner health aims to provide support and psychological care for doctors, dentists and pharmacists who may have a mental health issue or who may have developed a substance use issue. We aim to support practitioners to recover and to help them remain at work or return to work healthy and well.

REASONS FOR PRESENTING TO PRACTITIONER HEALTH

We continue to raise awareness of the service and what we provide. Our aim is that every doctor, dentist, and pharmacist should know that the service exists and the pathways to accessing help. Most practitioners will never need our service, but they may be in a position to direct a colleague to seek help should the need arise. We strongly advocate that all practitioners have their own GP who in turn can refer the individual to PH as necessary.

Confidentiality is a cornerstone of the programme. Practitioners can be assured of the highest integrity and confidentiality in their interactions with the Practitioner Health. Confidentiality is fully assured for all practitioners who either refer themselves or are referred to us by an outside party.

Delivering high quality and safe healthcare is a demanding job. The link between physician wellbeing and patient outcomes is well documented in the literature and when a practitioner is not functioning at their best there are more medical errors and reduced patient satisfaction. We notice however that many practitioners who present to Practitioner Health have worked beyond their capacity resulting in symptoms of anxiety, depression, substance use issues or burnout. Sadly, some would have reached such a level of distress that they are contemplating suicide. Ensuring practitioners are cared for and valued is vital in our health service. Providing access to support in a timely and professional manner is essential as we recognise that our colleagues can be slow to seek help and often delay until they are in crisis. Practitioner Health has a range of psychological supports at our disposal, including direct access to consultant psychiatry services.

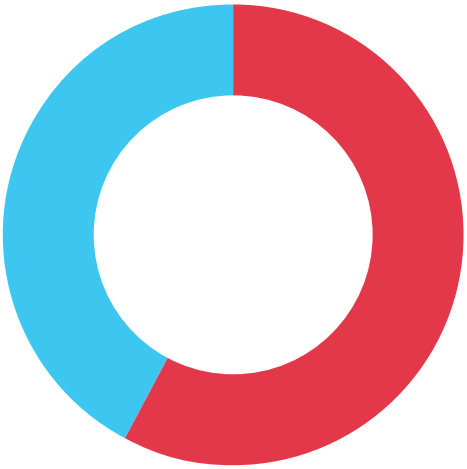
PH is a fully independent organisation at arm's length from regulatory bodies but our work is underpinned by a memorandum of Understanding with each of the regulatory bodies. As part of our initial and ongoing engagements with a practitioner, we always assess if the practitioner constitutes a danger to the public. When required, a practitioner may be stepped down from work to allow them to focus on their recovery while getting the necessary medical and psychological supports from PH. Our main aim is to support practitioners to be well while continuing to work or to return to work in a healthier frame of mind.

ANALYSIS OF PRESENTATIONS TO PRACTITIONER HEALTH IN 2023

There were 107 new presentations to PH in 2023. In addition, 10 practitioners who had previously attended the programme contacted us again and re-engaged. At presentation, each person is assessed by one of the doctors on the PH team and a care plan is agreed with them. A range of treatment options is offered, including psychological supports, medication management, inpatient treatment or onward referral as appropriate to the individual's needs. The programme continues to expand its network of therapists around the country. These therapists are familiar with the nuances and complexities of working with practitioners. Where necessary, PH can offer therapy sessions free of charge depending on the financial needs of the patient.

Most of the new presentations in 2023 were from doctors. This reflects the increasing awareness of the service amongst the medical profession as well as signposting from the training bodies, occupational health, GPs and the Irish Medical Council.

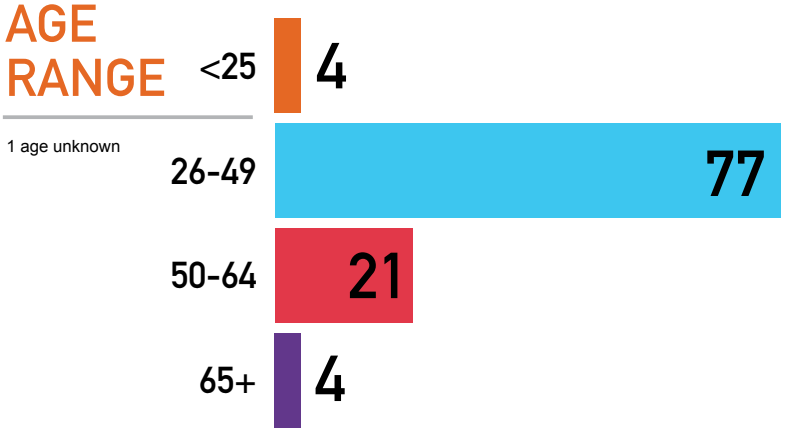
OVERALL PRESENTATIONS 2023



MALE V FEMALE

62 FEMALE
45 MALE

AGE RANGE



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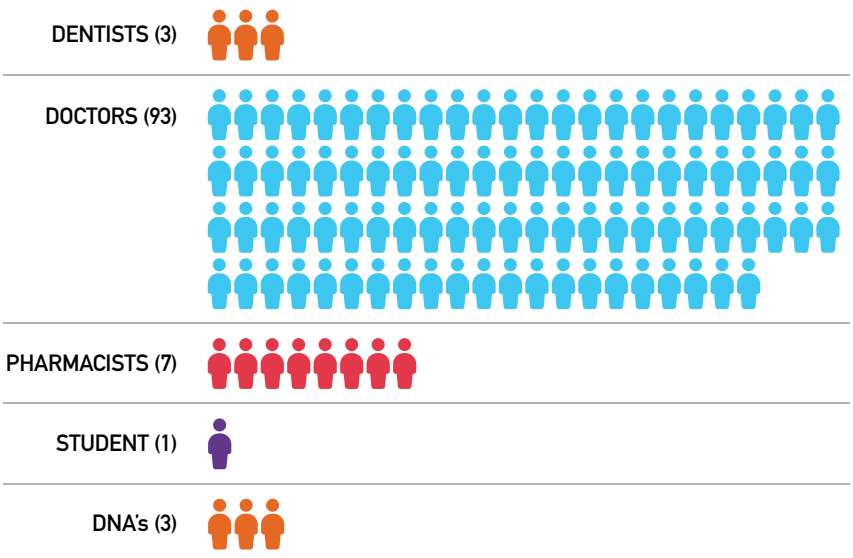
PRESENTATIONS BY OCCUPATION



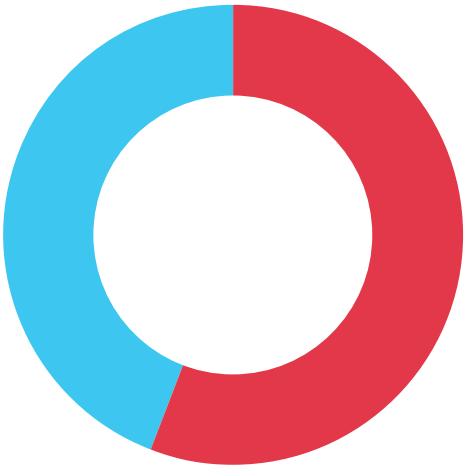
NEW DOCTOR REFERRALS

As in previous years, 68 doctors were in the younger age category and this vulnerable group benefit from our support and guidance at this early stage in their careers. While acknowledging the range of supports provided by the training schemes, the intern support programme and Occupational Health programmes are offered to the younger cohort of doctors, some prefer the option of support from our confidential programme.

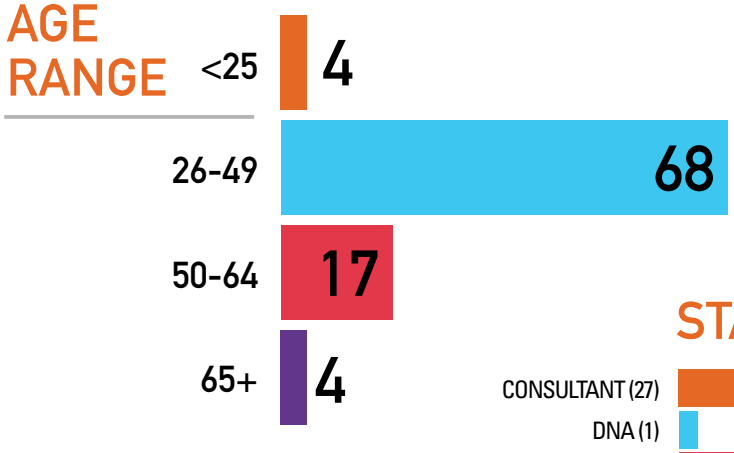
We note that 18 of those presenting were graduate entry doctors and we are mindful of some additional stressors in this particular group. In 2023 we saw a significant increase in the number of new presentations from senior clinicians, both consultants and general practitioners. This highlights the need for the service for this particular cohort. The discrete and confidential nature of the programme is essential for this cohort so that they can feel safe in coming forward to seek help.

MALE V FEMALE

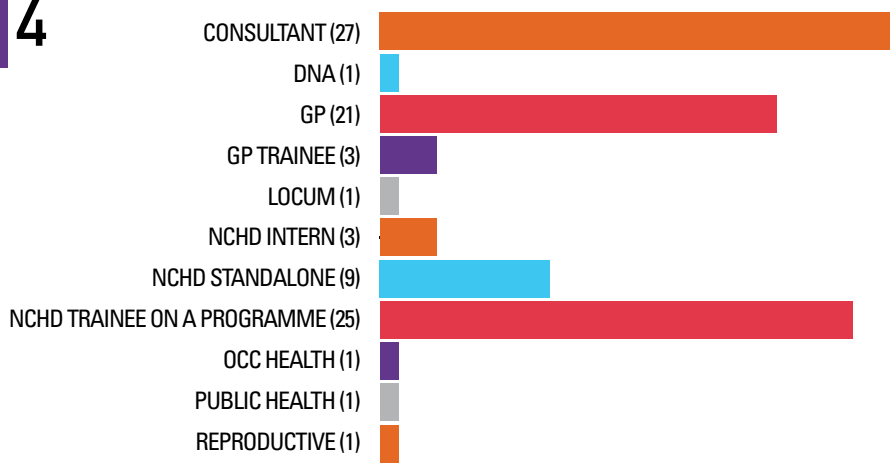
52 FEMALE
41 MALE



AGE RANGE

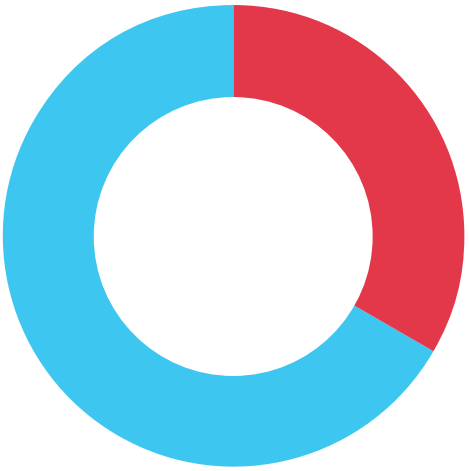


STAGE IN CAREER



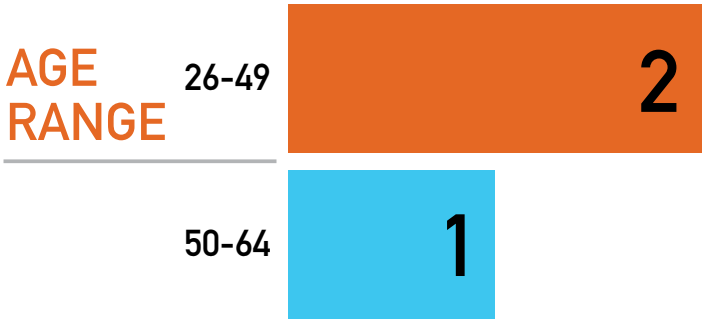
NEW DENTIST REFERRALS 2023

The number of dentists presenting remains very low as has been the case in previous years. Although the reports in the literature would suggest higher levels of stress and mental health issues amongst dentists when compared to the general public this does not appear to manifest in dentists seeking help with these issues. This is something that would warrant further investigation to understand what the barriers to seeking help might be. We acknowledge the regular communication from the various dental bodies about the programme and encourage ongoing messaging through social media and all other channels.



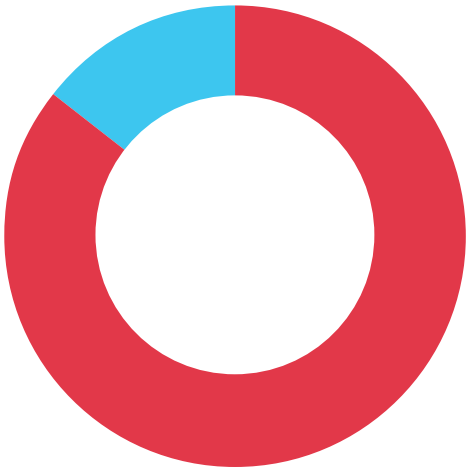
MALE V FEMALE

1 FEMALE
2 MALE



NEW PHARMACIST REFERRALS 2023

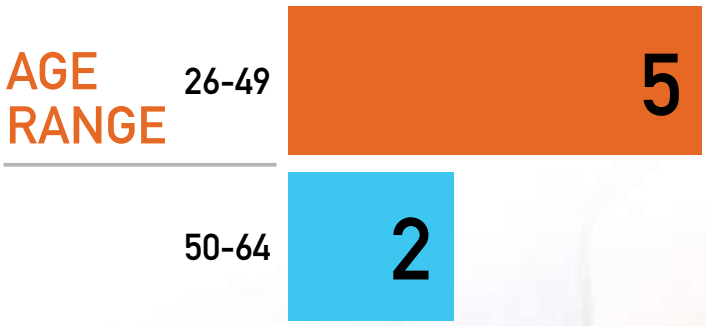
Pharmacist presentations in 2023 remain low, although at 7 it is slightly higher than in 2022. Most of the pharmacists attending in 2023 were also attending the Pharmaceutical Society of Ireland having been referred there prior to attending Practitioner Health. Our communication and collaboration with the Pharmaceutical Society of Ireland is a positive experience however our aim is to have pharmacists presenting before an issue becomes a regulatory one.



MALE V FEMALE

6 FEMALE
1 MALE

AGE RANGE



SAMPLE PATIENTS

Please note that the names used in these case studies and some details have been amended to protect the identity of the individuals.

PATIENT 1

SIOBHAN - A GP TRAINEE IN HER 20'S

Siobhan was referred by her GP as she had developed severe OCD type behaviours. This presented with excessive hand washing as well as ritualistic behaviours. She was seen urgently by our service due to the acuteness of her symptoms and level of her distress. She put on sick leave by her GP. Siobhan's difficulties started during Covid when she was isolated from family and friends. There had been a family bereavement during this time and she was unable to attend the funeral as she was working in another part of the country during the severe lockdown period. This had greatly upset her but she had not spoken about it in any detail. Her tendency to being perfectionistic and self-critical escalated over the following months and manifested itself in the OCD type presentation. Following initial assessment, she was medicated and was regularly reviewed. Over time her symptoms subsided and she was given the opportunity to explore what had triggered this episode. Siobhan is doing very well and is back at work. She will continue to be supported by Practitioner Health.

PATIENT 2

MARK - DENTIST IN HIS 30'S

Mark attended as he was feeling stressed and anxious. His sleep was poor and he was having ruminative thoughts. His symptoms were predominantly in relation to being overworked and due to changes in his working arrangements. Staff in the practice had noticed he was irritable and had encouraged him to seek some support. Mark had a history of depression and had been medicated in the past but had come off his medication a year previously. At assessment it was decided that he needed to recommence his medication and he was supported with ongoing regular reviews.

PATIENT 3

PATRICK - NCHD IN HIS 30'S

This trainee self-referred to the programme as his partner was concerned about his mental health. He reported feeling anxious all the time as well as feeling overwhelmed and exhausted at work. He had a history of anxiety and depression as an adolescent and with the pressure and responsibility of his job, he felt that this had now recurred. He had not sought help as he felt ashamed and fearful about the consequences of declaring his difficulties. At initial assessment he admitted to resorting to taking Xanax to help with the anxiety and to help him to sleep. His pattern of medication misuse was intermittent and not dependent use. He was stepped down from work and a programme of regular reviews, therapy and drug screening was put in place. After a period of rest and recouperation he recovered very well. He did not require medication but Patrick gained insight into his aberrant coping strategies as well as recognising his need for better self-care. He is committed to taking exercise and getting good sleep to protect his mental health.

PATIENT 4

PAUL - PHARMACIST IN HIS 30'S

Paul was referred to Practitioner Health following his discharge from a psychiatric hospital where he had completed 4 week in-patient programme with a dual diagnosis of depression and alcohol misuse. His recovery was good and he was committed to ongoing attendance at AA meetings as well as the aftercare programme. Paul was keen to return to work which we were supportive of and Practitioner Health was able to assist with ongoing drug screening to evidence his sobriety as well as ongoing clinical reviews. Paul is now back to work under supervision and is making a good recovery. This case remains active.

PATIENT 5

MAIRE – CONSULTANT IN HER 50'S

Maire was referred to the programme by a consultant colleague. She was experiencing conflict in the workplace and this was taking a significant toll on her mental health. She was tearful, had very low energy and was poorly motivated to engage in any activities. She described the conflict at her opinions being ignored, decisions taken by her colleague without her consent and generally being humiliated in front of others. Her confidence had been badly shaken and she was anxious when going in to work – this was completely out of character for her. In addition, this was impacting hugely on her personal life as she was ruminative and consumed by what was going on at work.

Maire had attempted to deal with her situation informally and was reluctant to go the formal route with her grievance as she felt this would invite even more stress for her. Instead, she was contemplating quitting her job as a way of resolving matters. Our role in this case was one of supportive listening and reassurance. Maire was encouraged to find her voice and to stand up to the bullying behaviour. In time, she was able to gain perspective on her role and restore her interest in her job and enjoy her life outside of medicine also.

DR AIDEN MEADE ESSAY AWARD 2023 /2024

This award is now in its third year and was set up to honour the memory of Dr Aiden Meade who directed the original Sick Doctor Scheme for many years. The aim of the award is to encourage reflection on issues relating to the health and wellbeing of registered practitioners. We are particularly keen to promote awareness of good health and wellbeing amongst the medical, dental and pharmacy undergraduate community. Awareness of the Practitioner Health programme and the non-judgemental, confidential nature of the service it provides is a further motivating factor in establishing the award.

UNDERGRADUATE WINNING ESSAY

Chronic illness in doctors: a source of wisdom, not weakness
(Anonymised)

I have been a medical student for five years and a patient for over a decade. Juggling both roles at the same time has provided copious opportunity for reflection on practitioner health and wellbeing. With my journey in medical school soon coming to a close, I have come to realise that the trickiest concepts I've had to get my head around these past few years have not been from textbooks. Instead, the tougher lessons have been about balance, self-care, rest, self-acceptance, and tenaciously learning to navigate a career that is not designed for people like me. As I have slowly learned to balance two seemingly opposing roles, I have developed a unique insight into medical training from a patient perspective. I believe such insights are paramount to changing culture within medical schools and hospitals for everyone, not just those with ongoing illnesses. While my own observations and the associated literature are largely related to medicine, I anticipate significant overlap across other demanding courses and careers within the healthcare profession, including but not limited to dentistry and pharmacy.

Recent data from the US shows that more than half of adults have at least one chronic condition (He et al 2018), while less than 5% of medical students and 3% of practicing doctors have a chronic illness or disability (Meeks et al 2019, Nouri et al 2021). It wasn't until I started medicine that I realised I was significantly outnumbered in this regard. From the beginning, it was common to hear my fellow classmates boast about how many hours of study they had done that week, or how much sugar and caffeine they had consumed to get them through a long night of revision. There is an accepted assumption among my peers that medical school – and life as a junior doctor – is a time when it is normal to push yourself beyond your limits. Despite teetering on breaking point, it is an acknowledged rite of passage and period of self-neglect that we must all go through to earn our prestigious doctor stripes. As a patient suffering from a chronic illness, however, I am expected to listen to my body and keep my health the number one priority. I am supposed to eat well, sleep enough, keep stress to a minimum, attend all my hospital appointments, and invest a lot of time in looking after myself. After all, this is what I will be encouraging my future patients to do.

My naivety became apparent rather quickly. I struggled to integrate both roles but also find my own identity among the perceived duality. What stood out to me the most, however, was the observable separateness

between doctors and patients. Little about the medical curriculum or the structure of working life reflected the susceptibility of students or doctors to the same diseases as their patients. Among students, staff and even patients, there was an attitude of them versus us. The patient in the bed was not a doctor, and the doctor at the end of bed was not a patient. We were not one. I noticed my peers experienced a mix of denial and shame during common acute illnesses, often refusing to rest and ignoring their symptoms. The biggest concern was usually related to how inconvenient being sick was to their study plans. There was little regard for treating themselves as they would a patient. I also witnessed colleagues ignore worrying signs of deteriorating mental health, as it was just accepted as part of the process.

McKevitt and Morgan (1997) carried out interviews with sixty-four doctors, all of whom had experienced either physical or psychiatric illness during their own medical training. This study revealed a popular, albeit often unspoken, opinion in medicine: Illness is not appropriate for doctors. To quote one of the participants from the study: “Illness doesn’t belong to us. It belongs to them, the patients. We need permission to be ill”. The stereotype that doctors are invincible bastions of health, and somewhat superhuman, is embedded in our cultural values of the profession. It is ingrained in the ethos of medical schools, where students are required to always perform at their best and commit to giving up a substantial portion of their lives to their studies. For junior doctors, it is acknowledged that the hours are long and often intolerable, and that over half experience burnout (O’ Connor et al 2017, Gunasingam et al 2015). Darwin’s survival of the fittest comes to mind. Among medical students, 27% meet the criteria for a diagnosis of depression, and more than 1 in 10 experience suicidal ideation (Rotenstein 2016).

Dentists and dental students are also at high risk of burnout (Singh et al 2016). Nevertheless, it is only through conspicuous displays of dedication and sacrifice that the ladder can be climbed. But we must first prove that we can cope with the pressure. In this kind of environment, where competition is rife and the stakes are so high, is it any surprise that disclosing an illness might feel like an admission of weakness?
You may be aware of the cliché that doctors are notoriously bad at seeking help for themselves when they are sick. There is also a related saying that if doctors do get sick, they make the worst patients. According to Clare Gerada, medical director of the NHS Practitioner Health Programme, doctors are reluctant to disclose their own symptoms due to fear of stigma and possible career consequences of admitting illness (The Lancet 2016). As a result, it is not uncommon for a doctor to present late with potentially serious complications. Personally, my illness was something I tried to keep hidden from most of my classmates and university staff members, where possible. I never made a conscious decision to keep it a secret – but it was not something I wanted many people to know about me either. I had never before questioned whether my hesitancy was related to an underlying shame of not being a perfect medical student, although perhaps I do have a deep-rooted, subconscious inferiority complex. Due to the COVID-19 pandemic, my illness came close to jeopardising my place in medical school when I was not cleared by occupational health to undertake my clinical placements. I was disheartened by the realisation that I am only at the very beginning of a long career that does not make enough allowances for those who are sick. I also became acutely aware that things would have run a lot smoother had I chosen to omit my illness during our pre-placement assessment. It has certainly made me more wary of future disclosures, a privilege that other healthcare professionals with more visible markers of illness or disability do not even have. Furthermore, I am conscious that any stigma experienced by those of us with physical illness is minimal in comparison to my colleagues with mental illness, where there is a real fear that certain psychiatric diagnoses can even pose a threat to their medical licence (Mehta et al 2018).

When medical education fails to address the stigma of illness among medical students and doctors, a huge opportunity is missed to demonstrate the true value for clinical practice of knowing what it is really like to be a patient. It also makes medical schools fall short in their mission to support their students and promote diversity within the medical profession. A 2007 study (Woolf et al) looked at medical students who faced personal illness during their medical degree. These researchers found that although the experience of illness negatively affected exam results in the short term, it was strongly associated with increased empathy, more professional behaviour and improved patient centred care, potentially due to reflective practice and transformational learning processes. Qualified doctors with long-term illnesses have also self-reported more compassion and understanding about what it really means to be patient (BMJ 2004). There has been a wave of interesting research into the far-reaching benefits of empathy in doctors. For example, patients who rated their surgeon as very caring during their hospitalisation were over 20 times more likely to rate the outcome of their surgery as positive (Steinhausen et al 2004). There is even an association between a quicker recovery from the common cold in patients who have more empathetic doctors (Rakel et al 2011), which reflects the potential effect of more positive human interactions on the immune system. Fostering empathy in medical students is obviously a complex and multifaceted process, but perhaps more enlightenment on the human side of illness might be of benefit in this regard.

Healthcare students and professionals need a safe environment to disclose if they are ill or feeling unwell, without the fear of judgement and potential negative consequences for their career. Furthermore, if medical schools and hospitals are serious about dispelling the misconception that illness is an unbecoming weakness, they need to start making more solid commitments to the health of their students and trainee doctors. Without this, they are only further perpetuating the false assumption that doctors and medical students are infallible superhumans. This would mean going beyond the typical 'wellness' activities that promote a good diet, plenty of exercise and regular meditation, which are the standard initiatives encouraged to counteract the sleepless nights and normalised relentless stress induced at the cost of pursuing your vocation. Moreover, the responsibility of navigating medical school with a chronic illness – or a disability – should also not fall wholly on the student either. The educational institutions themselves have a duty to consider how their own policies might impact the physical and mental health of their students, or whether their medical courses have barriers that discourage students with underlying conditions to even apply in the first place.

Healthcare, for most of us, is a lifetime vocation. Thus, it is inevitable that many of us will become practitioners with an underlying condition at some stage in our careers. Despite this, there is a wealth of evidence to suggest that illness among doctors is covertly frowned upon within the medical community. For change to occur, it needs to start at the level of culture within medical schools. Instead of regarding illness as a source of weakness, it should become more valued for the wisdom, expertise and insight that it gives. At a teaching level, this could involve creating more opportunities for clinical teachers who inhabit both the patient and doctor role, and who are willing to be vocal about how their lived experience with illness has informed and benefited their own practice of medicine. Students with a chronic illness could also be encouraged to share how they are succeeding in medical school despite their hurdles, as such stories can be a source of well-needed inspiration and hope for other medical students in the same position. The medical school curriculum also needs to include more input from patients in general, regardless of their professional background.

Medical school teaches us everything we need to know about the pathophysiology and management of disease. From my experience, however, it is failing to teach us enough about what it is like to live with a disease. This does not mean the complications and symptoms of illness or the side effects of medication, but what it is truly like to be a patient. The loss of identity. The uncertainty. The grief for a previous healthy life.

The stigma. The loneliness. The stress on relationships. The consequences of reduced income. The fear of the future. The waiting. The dependence on others. An endless list of obstacles that, through no fault of their own, can be unbeknownst to those who have not experienced them. But medical education can shift this. It has the power to make the wisdom of personal illness a bigger part of the professional identity of medical students and doctors who are lucky enough to have their full health. It also has a responsibility to remind us often that it is okay not to be okay. Until this happens, we might fall short when patients – and doctors worried about seeking help – need us the most.

POSTGRADUATE WINNER

The hamster wheel by Dr Caoimhe Dalton

It is Saturday morning. I wake in a bad mood. I had a silly fight with my boyfriend last night before he left to fly to a rugby game in London today. I decide to prescribe the silent treatment as I go for a quick run in the park. I make my way over to my home where my Mum is busy baking scones as a treat before I go to work. Everyone is looking forward to a relaxing weekend. My sister asks me if I would like her to plait my hair before I leave. I start to tear up a little bit because the kindness she openly radiates from her face is not something I have encountered too frequently of late. Her gentle hands comb through my hair tightening every chink in my armour I need for this day.

Emergency medicine was not an area that I had ever anticipated working in and when it came as part of my allotted jobs for basic medical training, I approached it with the kind of anticipation a mouse would facing a tiger. I park my car and scan into the department. I wave to some familiar faces and walk towards the patient tracking board to pick up my first patient.

The first patient is a 90-year-old male. His transfer letter reports that he was transferred from his nursing home because he was short of breath and tachycardic this morning. His family arrives very concerned about the fall he had. ‘What fall?’ I say. ‘The fall he had this morning before he started breathing funny’ they say. I call the nursing home. Unfortunately, his usual nurse is on break and the relieving nurse can tell me that the fall was unwitnessed and nothing else. I speak to the radiology registrar to ask her to vet my first brain scan for the day.

The second patient is a 28-year-old female. I am flagged to her by an exasperated nurse. The patient has attended with worsening suicidal ideation. Her mother is driving the nurses crazy asking for medical review because she has been there for 3 hours. I check the patient tracking board. It has been 2 hours and 4 minutes since she was triaged. I send her blood tests because no psychiatrist will see her without them, and we chat through how long she has been feeling this way for. I complete a physical exam and head off to order the phlebotomy stickers. Her mother follows me through and asks me when the psychiatrist will be down. I say we need to have completed a full medical work-up first to which she responds that she was lied to at triage. She was informed that the on-call consultant was already on his way, telepathy involved presumably. She tells me it is my fault if her daughter kills herself. I do my best to rescue the situation, but she storms off and I am left like a helpless child, holding my silly little blood bottles.

The third patient is an 81-year-old male. He has a history of benign prostatic hyperplasia leading to multiple episodes of acute urinary retention. Yesterday he went to Urology clinic. The consultant said his bladder

volume was normal and his prostate, while large, was not necessarily obstructing. Unfortunately, since then, the man hasn't passed urine in 16 hours and his bladder contains approximately 750ml of urine. I set up to insert a urinary catheter but as the patient lies back, his face goes bright red, and he starts to gag. He bolts upright and showers my sterile trolley and the surroundings in wine-coloured vomit with clumps of black stuff. I hopefully ask his daughter if he has had Ribena recently. She says he hasn't had anything to eat or drink in 10 hours. I sigh and call the switchboard to ask them to connect me to the surgical senior house officer, please.

The fourth patient is a 30-year-old female. She was kissing her partner earlier and noticed sudden onset tongue and lip swelling. There is no airway compromise, and the swelling has stabilised after 2 antihistamines. I ask her if she knows what she possibly could have reacted to and surprisingly she tells me that it was almost certainly the oestrogen gel her trans partner has been applying to her face. This was the first-time direct contact has been made with it freshly applied and the patient has no other known allergies. I tell her we will keep an eye on her for a while and after 4 hours of observation and an improvement in the swelling, I say that I am comfortable for her to go home with some safety netting advice. I'm not quite sure how to advise on avoiding a similar situation but I just ask her to steer clear of the oestrogen gel for now.

The fifth patient is a 54-year-old male. He is accompanied by his sister who tells me that he has been having non-stop conversations with himself for a week. He is pacing the floors of room, too active to listen to a complete question to answer. He has been too scared to leave his house to collect his medications, so his depot anti-psychotic has been on inadvertent hold for a while now. The psychiatry registrar won't see him without a urine drug screen, so we wait.

The sixth patient is a 43-year-old female. She has inflammatory bowel disease and has been passing clots of blood in the toilet for several days now. She is clinically dehydrated so I start a fluid bolus and give her some paracetamol. My registrar advises me to prescribe some hydrocortisone and treat the presentation as a disease flare. I call the medical registrar to refer her for admission. The medical registrar is furious. How could I have given steroids to someone with stricturing Crohn's disease on colonoscopy 12 years ago. I decide the best thing I can do is nothing further. She has been referred to expert hands for further management.

The seventh patient is a 74-year-old female. She has moderate cognitive impairment and is accompanied by her daughter. The patient has had intermittent severe scapular pain for 3 months now. Her blood tests are unremarkable, so I discuss the case with my registrar. Apparently, she needs a CT aortogram to outrule aortic pathology. The radiology registrar is not enthused by the request with such a subacute history, but my real challenge is the big green cannula that the patient needs placed for the contrast. I make two attempts because the patient is so crippled by arthritis she can't straighten her arms. She is crying now, and her daughter looks less than impressed with my efforts.

I run to take my 30-minute break. I go to the communal kitchen and heat up my Bolognese. I don't know what I was thinking last night as I was packaging up my lunch. I clearly ate more of it in that sitting than I have left for myself now. I text my boyfriend to say how I am getting on. He responds within seconds to say he has been hoping I am getting through the day alright and tells me the score of the match. The nurses and health care assistants at the table are talking about lip fillers. The health care assistant says she did the course but wouldn't even think about doing the injections now based on all the tissue ischaemia she has seen sent

around on WhatsApp. I stay quiet. This is not my territory. One of the nurses is snoring on the couch that you are only allowed to sit on when you have finished your food.

The eighth patient is a 24-year-old male. He is from Brazil and though his English is passable, I am supplementing our conversation with google translate, which slows down the interaction significantly. He has had flu-like symptoms for a month now and the weight has been falling off him. I order him a chest x-ray and send some routine blood tests. He has a large mediastinal mass and significantly elevated inflammatory markers. I speak to the medical registrar to refer him for further work-up. I hope he will be okay.

The ninth patient is a 31-year-old female. She is under the influence of multiple drugs and in far too much distress to tell us what the problem is. No matter, her right shoulder is so far from its home socket that we know everything we need to for now. One of registrars asks me to relocate the shoulder while she takes care of the sedation. Once her sedation kicks in, the patient tells me we have met before. A moment later, she clarifies that by saying we have not met in person but that she saw me brandishing my nose job on television. She tells me it is a great nose. She has actually picked it from the catalogue for herself when she gets the money. The shoulder clunks back into place.

The tenth patient is a 77-year-old female. She has come in because this morning her feet were black when she woke. Her daughter explains this has been happening on and off for a while now. I am a bit stumped because she has adequate pedal pulses in both warm feet, normal power and sensation and no ulceration. I call the vascular registrar who doesn't think she needs admission but kindly offers her an appointment first thing Monday in the outpatient's department. I wave them off. They are delighted as it has only been 3 hours.

I drive home in silence. As I fly by the traffic lights, I redo every patient interaction that I can remember from today. How confident am I that I did my best for every one of them? I'm not sure. I sit and watch 20 minutes of Succession and have a cup of tea before bed. I change into my pyjamas. I lie down. I close my eyes. I think about all the other people working in the department and how they are coping, how they can possibly be less worried than me. I think about how I can do it better tomorrow.

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