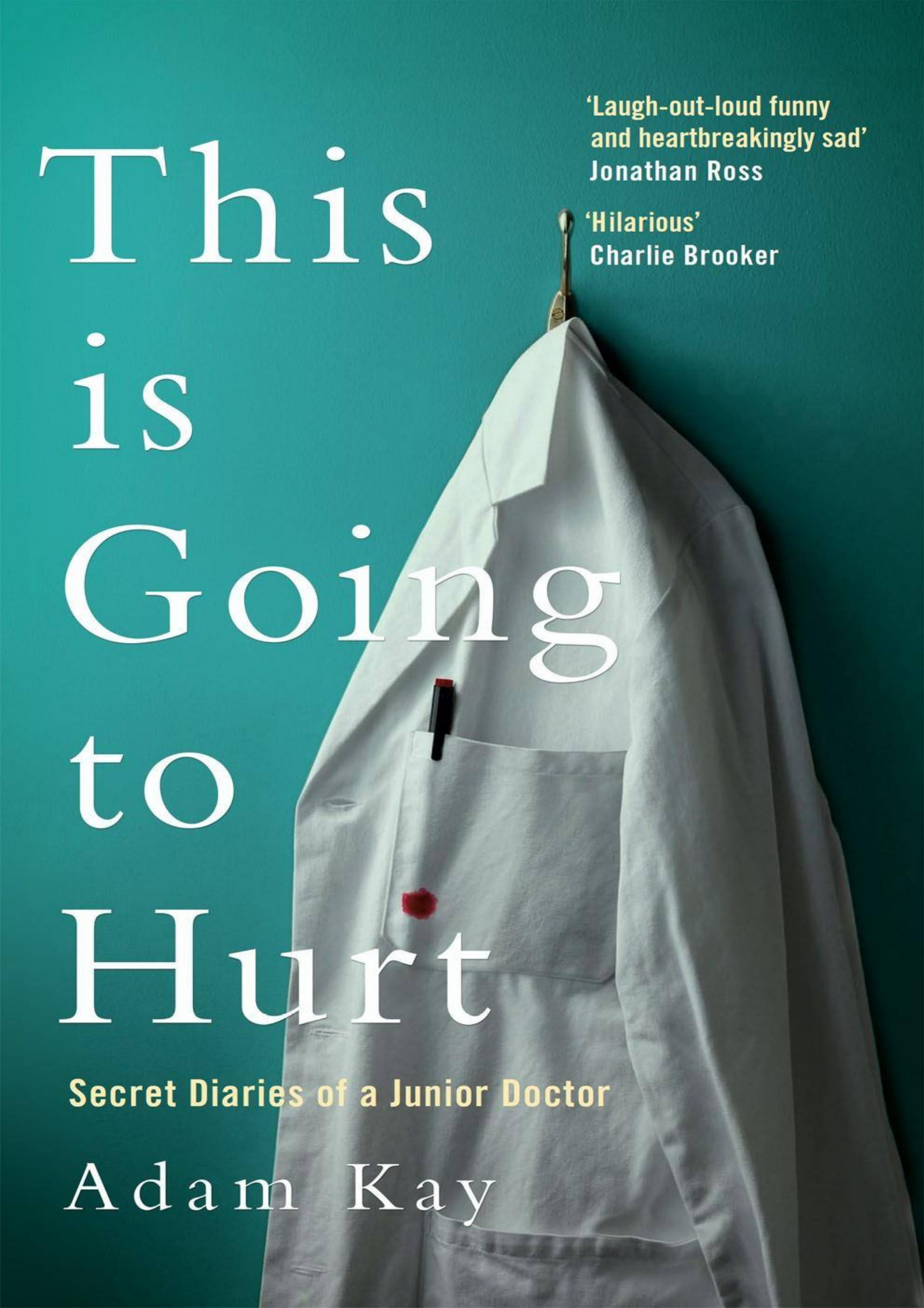
'Laugh-out-loud funny and heartbreakingly sad'
Jonathan Ross
'Hilarious'
Charlie Brooker
This is Going to Hurt
Secret Diaries of a Junior Doctor
Adam Kay

Adam Kay

This is Going to Hurt
Secret Diaries of a Junior Doctor

PICADOR

To James

for his wavering support

And to me *without whom this book would not have been possible*

A NOTE REGARDING FOOTNOTES

Read the fucking footnotes.

To respect the privacy of those friends and colleagues who might not wish to be recognized, I have altered various personal details. To maintain patient confidentiality, I have changed clinical information that might identify any individuals, altered dates[1] and anonymized names.[2] Although fuck knows why – they can't threaten to strike me off any more.

Contents

Introduction

In 2010, after six years of training and a further six years on the wards, I resigned from my job as a junior doctor. My parents still haven't forgiven me.

Last year, the General Medical Council wrote to me to say they were taking my name off the medical register. It wasn't exactly a huge shock, as I hadn't practised medicine in half a decade,[3] but I found it a big deal on an emotional level to permanently close this chapter of my life.

It was, however, excellent news for my spare room, as I cleared out box after box of old paperwork, shredding files faster than Jimmy Carr's accountant. One thing I did rescue from the jaws of death was my training portfolio. All doctors are recommended to log their clinical experiences, in what's known as 'reflective practice'. On looking through this portfolio for the first time in years, my reflective practice seemed to involve going up to my hospital on-call room and writing down anything remotely interesting that had happened that day, like a medical Anne Frank (only with worse accommodation).

Among the funny and the mundane, the countless objects in orifices and the petty bureaucracies, I was reminded of the brutal hours and the colossal impact being a junior doctor had on my life. Reading back, it felt extreme and unreasonable in terms of what was expected of me, but at the time I'd just accepted it as part of the job. There were points where I wouldn't have flinched if an entry read 'swam to Iceland for antenatal clinic' or 'had to eat a helicopter today'.

Around the same time that I was reliving all this through my diaries, junior doctors in the here and now were coming under fire from politicians. I couldn't help but feel doctors were struggling to get their side of the story across (probably because they were at work the whole time) and it struck me that the public weren't hearing the truth about what it actually means to be a doctor. Rather than shrugging my shoulders and shredding the evidence, I decided I had to do something to redress the balance.

So here they are: the diaries I kept during my time in the NHS, verrucas and all. What it's like working on the front line, the repercussions in my personal life, and how, one terrible day, it all became too much for me. (Sorry for the spoiler, but you watched *Titanic* knowing how that was going to play out.)

Along the way, I'll help you out with the medical terminology and provide a bit of context about what each job involved. Unlike being a junior doctor, I won't just drop you in the deep end and expect you to know exactly what you're doing.

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 nonacademic 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 vicecaptain 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.[4] 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 wideranging, 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.[5]

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 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 underutilized. 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.

* H is my short-suffering partner of six months. Don't worry – you'renot 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'tknow what a stethoscope is, this is probably a book to regift.

Wednesday, 18 August 2004

Patient OM is a seventy-year-old retired heating engineer from Stoke-onTrent. 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; 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.

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

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 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.

* 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.

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. To give myself a bit of credit, I didn't panic when the patient I was reviewing on the ward unexpectedly started hosing enormous quantities of blood out of his mouth and onto my shirt.

Sunday, 17 October 2004

To give myself no credit whatsoever, I didn't know what else to do. I asked the nearest nurse to get Hugo, my registrar, who was on the next ward, and meantime I put in a Venflon* and ran some fluids. Hugo arrived before I could do anything else, which was handy as I was completely out of ideas by that point. Start looking for the patient's stopcock? Shove loads of