Royal College of General Practitioners

Sheppard Memorial Compendium Essays 2026

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Winner of the Sheppard Memorial essay competition 2026, Postgraduate category

"Knowing Thy Neighbour: The Cultural Superpower of Irish Primary Care"

Author: Niamh McMullan, Postgraduate, 2nd Year, Ulster University

Golf umbrellas are like gold dust. Ever since moving across the border to Derry, I have never experienced rain like it. The problem is that ordinary umbrellas are simply not up to the task- a lesson I encountered yet again on a typical October morning as I hurried out the door to my General Practice (GP) placement. Despite every attempt to shield myself from the elements, I was left defeated, holding a limp and inverted frame in my hand. The Northwest rain had struck again.

Whilst waiting at the traffic lights, to my surprise, the rain suddenly stopped. I looked up to find a smiling gentleman holding a giant parasol over the two of us, under which he accompanied me all the way to the GP surgery door. Thanks to this act of kindness - so characteristic of Derry- I arrived with remarkably dry scrubs and a little more 'umph' to face the day ahead.

This was my first reflection of the morning. General practice in Northern Ireland is about much more than just reaching a clinical destination. Perhaps it is also about the act of accompaniment through a care journey. Here, as on the streets of Derry, to be known is to be looked out for.

Being known by a clinician over time can broadly be defined as having continuity of care (adapted from Haggerty et al., 2003). Continuity is not just a comfort but a clinical and strategic tool. Research across primary care confirms that seeing the same GP improves diagnostic accuracy and therapeutic trust, which translates into reductions in emergency department visits, hospital admissions and premature mortality (Engström et al., 2025). These findings reflect a clinical reality: being known by your doctor can save your life.

In the past, single-handed practices meant seeing the same GP was expected or in some cases the only option. However, with larger multi-partner practices and modern working patterns seeing the same GP is no longer a given.

Yet, continuity of care in general practice remains as important as ever-especially in Northern Ireland where operational access targets, workforce shortages and urban-centric health policies threaten its delivery. While continuity of care has evolved, we must preserve its core concept: being known by your clinician in your community. An ethos reflected across United Kingdom (UK) primary care looking to leftward shift healthcare closer to home.

Safeguarding continuity of care in general practice requires deliberate effort. As highlighted in the 'Improving Continuity of Care Toolkit' (Knight et al., 2021) the overarching point to remember is that continuity can be achieved even on the smallest scale-whether within individual clinical encounters, through workforce restructuring or via health policy considerations. Crucially, just as continuity of care looks different today than in the past, it also varies within and between practices. A scoping review of over 400 UK GP practices demonstrated that there is no "one size fits all" approach to implementing continuity (Fox et al., 2024). Although this variation complicates measurement, research increasingly points towards two standardised measurement tools: the Usual Provider of Care (UPC) index and the St Leonard Index of Continuity of Care (SLICC). Reaching consensus on these metrics is essential to evaluate and incentivise continuity across primary care. However, before measuring and implementing continuity in Northern Ireland, we must first understand what threatens it.

Firstly, rapid access may sacrifice continuity. Northern Ireland's primary care strategy closely mirrors the NHS England Neighbourhood Health Model (Department of Health and Social Care and NHS England, 2026) which prioritises access to acute primary care to alleviate demand on secondary care services. Undeniably, acute illness should be seen in a timely and efficient manner. To achieve this, the neighbourhood model directs minor presentations through community pathways like 'Pharmacy First' and Urgent eyecare services to preserve GP capacity for more complex acute illness.

Nevertheless, prioritising acute access may risk pushing continuity of care into the background. So, the question may not be how to manage GP appointment demand through temporary locum hires or list cutting, but how to simultaneously provide urgent care without sacrificing continuity. This may require looking at practice operations differently.

Continuity of care can be translated from principle into practice through a combination of individual habits and practice design. On placement, I observed simple measures, such as GPs wearing name badges and distributing appointment cards with their working days to improve the chances of patients returning to the same doctor for follow up. Beyond individual efforts, another tactic to preserve continuity was the use of micro-teams, where small groups of GPs shared responsibility for chronic disease clinics, such as diabetes.

Complementing these clinical adaptations, administrative staff play a role in protecting continuity. During my placement, receptionists who had undergone care navigation training

implemented a dual triage system separating acute from chronic complaints. Another innovative strategy I observed was the allocation of a daily 'on-call' GP who solely responded to urgent requests leaving availability for their colleagues to continue routine care.

Beyond these operational strategies lie the benefits of continuity itself in moderating GP demand. A longitudinal, trusting relationship with a GP may dissuade patients from booking premature or unnecessary routine appointments, thereby increasing overall appointment capacity. Although stoic patients may risk delaying care to wait for their named GP, clear safety netting and clinical endorsement may instil confidence in patients to access care from the wider GP team when necessary.

However, local practice initiatives cannot fully offset broader structural threats. In Northern Ireland, urban-centric health policies tend to overlook rural isolation and workforce shortages. Policies promoting neighbourhood models- characterised by centralised specialist hubs and digital triage- may work well for built up towns, but they leave more rural patients stranded by poor public transport and connectivity. On a GP home visit to a frail elderly patient, I was reminded of the fact that technology cannot replace the doctor down the road.

Geographic isolation affects clinicians as well as patients. While lone working and burnout are recognised challenges across primary care globally, they present acute risks to GP recruitment and retention in Northern Ireland. On placement, a local GP highlighted how well-intentioned policy can exacerbate this burnout. While the Health and Social Care Northern Ireland (HSCNI) actively promote multidisciplinary team (MDT) working, redirecting straightforward presentations to the MDT leaves the GP with a daily concentration of complex cases. Perhaps this is where HSCNI policy can help. Establishing cross-practice GP hubs may allow doctors to share clinical load whilst peer insight may reduce the risk of oversight associated with lone working.

Even so, before retention comes recruitment. The benefits of continuity itself could be the very enticement needed to attract GPs into Northern Ireland. Recruiting newly qualified doctors away from urban amenities may always be a challenge, often driven by work-life priorities (Ohman et al., 2025). For some however there may be leverage in the fact that rural general practice is not just a place to work but a place to belong. Rural GPs in Ireland report deep fulfilment and a strong 'sense of place' through lifelong care, though fear recruitment shortages may break this continuity (Hayes et al., 2023). Cultivating a 'sense of place' requires immersing GP trainees into the communities they serve. In Northern Ireland, this requires increasing GP trainee exposure to practices in rural and socioeconomically deprived areas (Butler et al.,2023). Such exposure can be offered through postgraduate rural placements, mirroring the Health Equity Focused Training scheme (HEE, 2023) in other parts of the UK.

Fundamentally, policy and workforce reforms exist for one main reason which is to support and care for the patient. In Northen Ireland, continuity offers accompaniment to patients

sitting on long secondary care waiting lists. In a high demand, zero cost service like the HSCNI, specialist backlog may always exist. During these years of waiting, a regular GP enables ongoing re-assessment as well as escalation or de-escalation of care as needs change. Most importantly, accompaniment reminds patients that their care journey in the interim matters just as much as the specialist outcome.

This accompaniment is especially vital for vulnerable groups who suffer most from fragmented care. In this way, continuity of care may function as a buffer against health inequity. A point reflected in the Inverse Care Law (Hart, 1971), where those in greatest need of care-such as the elderly, migrants or individuals with learning difficulties-often receive care the least.

Translating this principle into practice requires targeted continuity by assigning vulnerable patients to personalised GP lists. While some patients prioritise choice and flexibility, there is broad agreement among GPs that continuity should be reserved for those living with physical and psychosocial complexities (Bruch et al., 2026).

Ultimately, targeted continuity of care ensures that those who need care the most are truly looked out for. Continuity is not just a comfort in general practice, nor is it a given in modern healthcare. Instead, it is a necessity that must be actively preserved. While Northern Ireland faces unique challenges that threaten continuity, our rurality and close-knit communities provide a natural foundation for it to thrive. Here, the heart of the matter is simple: to be known is to be looked out for. That is our cultural superpower across Northern Ireland and too across of the island of Ireland.

As I reached the door of the GP surgery that rainy October morning and expressed my gratitude to John -the man who owned the golf umbrella- I was reminded of this sentiment in his response; “Ah, sure, that’s what neighbours are for.”

Declaration
This submitted work is original and contains no plagiarism or use of AI.

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Winner of the Sheppard Memorial essay competition 2026, Undergraduate category

Strengthening Community-Based Expertise in General Practice

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Coming to Ireland as a Canadian medical student, I quickly realized that understanding medicine extends beyond learning how to diagnose and treat disease. It also requires understanding the healthcare system where patients seek care. Although Canadian family medicine and Irish general practice share many underlying principles, my experience at the University of Limerick encouraged me to reflect on how differences in healthcare delivery can shape a patients' experiences.

Through the Early Patient Contact Program, I had the opportunity to engage with members of Limerick's community and develop a greater appreciation to the challenges patients face when navigating the healthcare system. My first patient encounter was particularly memorable as they discussed the profound debilitating musculoskeletal pain experienced, prolonged delays in accessing treatment and consideration for surgery abroad. Their experience raised a broader question. What happens when a patient's needs extend beyond the expertise or resources available in their local GP practice but could still benefit from additional care before reaching the hospital specialist.

Reflecting on Canada's enhanced skills family medicine model led me to think about how Ireland could further develop its existing system of GPs with special interests. Instead of adopting another country's approach, could Ireland better align enhanced clinical expertise with the needs of individual communities, while preserving the continuity, accessibility and comprehensive care of general practice?

The Gap between Community and Specialist Care

The COVID-19 pandemic exposed and intensified longstanding pressures within Ireland's healthcare system, especially delays in accessing specialist services. However, these challenges extend beyond the pandemic, raising broader questions about how healthcare resources are distributed and if more patients could receive appropriate care within their communities. Dermatology services in Ireland demonstrate some of the difficulties associated with addressing the specialist waiting lists through short-term capacity expansion. Following the pandemic, outsourcing and insourcing arrangements were explored to manage waiting times. An analysis identified substantial financial and operational challenges, including 1.32 million

euros associated with outsourced patient care [1]. Although these strategies can provide some temporary relief, their findings question the sustainability of relying on additional external capacity instead of strengthening public services.

Chronic pain services offered another example of inequalities in healthcare access. A national survey conducted in 2020 found that approximately 25% of patients awaiting outpatient chronic pain appointments had waited over 18 months, while 17% awaiting interventional treatments had waited over 12 months [2]. Furthermore, the survey also found shortages of multidisciplinary staff and geographical disparities in chronic pain service provision. These findings suggest that improving access requires not only increased specialist capacity, but also a stronger coordination between community and hospital services.

The patient I encountered during my Early Patient Contact Program brought these challenges into perspective. Their prolonged wait for musculoskeletal (MSK) care was not just an administrative delay. It affected their quality of life and influenced decisions about seeking treatment abroad. Although complex cases will continue to require specialist intervention, having more accessible community-based pathways could help support earlier assessments and conservative follow-up care.

Expanding community services must also account for the pressures already impacting Irish general practioners (GP). For example, workforce shortages, administrative burdens, poor communication and inadequate multidisciplinary support were among few of the more significant concerns identified amongst interviewed GPs [3]. These findings emphasize the importance of involving practicing GPs in healthcare planning and recognizing the differing needs of rural and urban communities.

Therefore, the challenge is not to transfer more responsibilities from hospitals to an already overstretch GP workforce. It is to consider if existing expertise, training opportunities and healthcare resources could be better allocated to support patients in a timelier manner.

Canada's Enhanced Skills Model

Canada offers an interesting perspective through its Certificates of Added Competence (CAC) program, established by the College of Family Physicians of Canada (CFPC). Beginning with emergency medicine certification in 1982, the program expanded to recognize additional competencies in areas like palliative care, care of the elderly, sport and exercise medicine, and family practice anaesthesia [4].

Research exploring Canadian family physicians' perspectives on enhanced skills practice highlights the potential benefits of this model. Participants described increased opportunities to strengthen collaborative care through shared-care models, where physicians with additional competencies could serve as clinical resources for neighbouring family doctors. This can allow patients to access more specialized expertise while preserving their therapeutic relationship with their family physician. Participants also identified the potential to reduce travel costs in rural and remote communities and improve professional satisfaction by aligning clinical practice with personal interests [4].

However, these opportunities must be considered alongside the potential consequences for family medicine. Physicians undertaking enhanced-skills practice may face difficulties balancing multiple clinical roles, increased working hours and competing responsibilities [5]. Moreover, if additional training encourages physicians to move away from general practice, the benefits of enhanced expertise could come at the expense of access to everyday primary care.
Thus, the Canadian experience offers lessons in both opportunity and caution, rather than a model to replicate. For Ireland, I think the objective should be to ensure that enhanced competencies complement the general practice and respond to the specific healthcare needs of the communities they serve.

Expanding Ireland's Existing GP Special Interests Foundation

Canada's enhanced-skills model offers valuable lessons in developing formally recognized additional competencies within family medicine. However, these lessons are particularly relevant because Ireland is not starting from scratch.
The Irish College of GPs already provides postgraduate education opportunities in areas including dermatology, community gynaecology, palliative care, addiction management and musculoskeletal medicine [5]. These programs demonstrate an existing commitment to developing additional clinical expertise within general practice.
Ireland has also made significant progress towards delivering more care in community settings. The Health Service Executive's Enhanced Community Care (ECC) program aims to strengthen collaboration between general practice, multidisciplinary community teams and hospital services. In 2024, the HSE reported over 645,000 GP-led chronic disease reviews and 133,000 patient contacts through Community Specialist Teams for Older People [6]. These developments reflect the ambitions of Sláintecare to improve regional access to integrated, patient-centred care [7].
Existing MSK services further demonstrate the potential of multidisciplinary care pathways. Physiotherapist-led MSK triage services have been developed to improve access to appropriate assessment and management while reducing unnecessary progression to consultant-led services [8]. Rather than duplicating physiotherapy services, GPs with enhanced MSK competencies could potentially complement these pathways through collaborative assessment, management and referral of selected patients.
However, the availability of postgraduate training does not necessarily ensure that enhanced expertise is equitably distributed or translated into accessible clinical services. Questions about how additional GP competencies are recognized, funded and incorporated into regional care pathways must still be explored. Ireland's Strategic Review of General Practice also highlights the importance of workforce capacity, training and sustainable service delivery [9].
Thus, training a GP in additional clinical skills may not, on its own, guarantee that patients will benefit from those additional skills. The biggest challenge is to ensure that the enhanced expertise is supported, accessible and directed towards the communities where it is most needed. Drawing on observations from Canada's experience, a more coordinated framework

could help align enhanced clinical skills with local community needs while preserving the continuity and care that defines general practice.

Community Responsive Enhanced Practice Proposal

Rather than expanding the GP-special interest training uniformly across Ireland, I propose a Community-Responsive Enhanced Practice (CREP) framework where additional training and clinical opportunities are guided by regional assessment of unmet healthcare needs.

For example, a rural community with limited access to chronic pain services could benefit from GPs with enhanced musculoskeletal competencies, while an underserved urban community may require more expertise in addiction medicine. The objective is not to replace Ireland's existing multidisciplinary services, but to strengthen them through coordinated, community-responsive care.

Chronic pain provides an example of where this approach could be explored. In a national survey of publicly funded pain services, 27 consultants were identified to provide chronic pain management across 16 hospitals in 2020. This is equivalent to 0.55 whole-time equivalents (WTE) consultants per 100,000 people [2]. Interestingly, consultant capacity was very unevenly distributed. The former RCSI and University of Limerick Hospital Groups each had 0.21 WTE consultant per 100,000 people, compared with 0.45 in Dublin Midlands [2].

These figures demonstrate how national staffing totals can hide regional inequalities in access to specialist expertise. However, specialist staffing alone should not establish where enhanced GP services could provide the most benefit. Local referral patterns, patient community needs and existing multidisciplinary resources should also be considered.

I believe these differences should inform where enhanced GP competencies are developed and supported. Ireland already offers postgraduate training in musculoskeletal injury management, providing a good foundation where more structured community-based roles could be developed. GPs with additional training could work alongside physiotherapists, psychologists and specialty pain teams to provide earlier assessment, evidence-based conservative management and coordinated follow-up. However, complex cases and specialist interventions should remain under the care of appropriately trained consultants.

To translate this idea into practice, I propose five interconnecting components.

First, identify the regional healthcare needs in different communities across Ireland. HSE Health Regions could collaborate with practicing GPs, community healthcare professionals and hospital specialists to identify priority clinical needs. Assessments should consider the referral patterns, waiting times, community characteristics and current service capacity. This process should exemplify the experiences of patients and clinicians to provide a more accurate picture of the community needs.

Second, a supported and structured training program should be implemented. Interested GPs could pursue enhanced competencies relevant to specific community needs through defined

learning objectives, supervised clinical training and competency-based assessment. Through my own experience with problem-based learning at medical school, I have come to appreciate how self-directed learning, combined with peer collaboration and guidance from supervisors could strengthen the application of scientific knowledge in clinical practice. Similarly, this framework could incorporate these principles while building on the already existing Irish educational opportunities.

Third, it is important to preserve the continuity and comprehensiveness of general practice. Enhanced practice must complement the general practice role, not replace it. Participating GPs could maintain their usual clinical responsibilities while also undertaking some protected sessions in their enhanced areas. Workforce planning should be conducted to make sure that these arrangements do not reduce access to GP appointments.

Fourth, a funded network clinic and referral pathway must be established. Instead of requiring every practice to develop the same expertise, participating GPs could provide enhanced services through shared network clinics that are accessible to the neighbouring practices. Thus, with a clear referral criteria and communication pathways, patients could benefit from additional expertise and maintain their relationship with their usual GPs.

Finally, we must evaluate outcomes before nationally expanding. The implementation of this model could begin with a small number of regional pilots. Their effectiveness should be evaluated through patient reported outcomes, waiting times, geographic accessibility, referral appropriateness, and effects on comprehensive GP capacity. This evaluation will help determine if enhanced practice offers meaningful additional benefits rather than duplicating already present multidisciplinary pathways.
In terms of funding, Ireland's €27.4 billion health budget for 2026 reflects a commitment to improving access and strengthening service capacity [10]. However, this proposal would require dedicated and transparent funding arrangements.
By building on Sláintecare and the HSE's regional structures, CREP could offer a practical way to connect GP professional development with community needs, while preserving the continuity and comprehensive care of general practice.

Reflection
Although a community-responsive approach could offer potential benefits, it is important to recognize and address its potential limitations.
Like Canada, Ireland faces a shortage of GPs, which poses the greatest concern for this proposal. Encouraging physicians to pursue additional competencies could further reduce the time available for general practice, especially in areas already struggling to recruit and keep doctors. Consequently, this program may unintentionally worsen inequalities if it draws physicians away from comprehensive care. Therefore, it is important to distinguish that CREP is not intended to resolve the GP workforce shortage, but rather to address inequalities in

access to specialized care in communities. Its implementation would need to complement greater efforts to strengthen Ireland's GP workforce instead of placing more demands on an already overstretched workforce.
Funding may also present another challenge. Introducing a new framework requires investment in structured training, clinical supervision, network clinics and ongoing evaluation. These resources alongside competing priorities within the healthcare system should be considered. Although strengthening community-based care could reduce unnecessary hospital referrals, its benefits may not outweigh the initial costs. Therefore, sustainable funding and thoughtful resource allocation is needed.
Finally, new inequalities could be introduced if training opportunities become concentrated in well-resourced urban areas. Good planning, regional needs assessment and practical support from GPs should be considered during program implementation.
These concerns reinforce why I prefer having a small, independently evaluated regional pilot over immediate national expansion. A successful pilot would demonstrate the feasibility of this program, evaluated in terms of clinical benefit, patient and GP satisfaction and sustainable costs. It is important to ensure that there is no reduction in the care provided by general practice to patients. Limited benefits should be taken into consideration to improve the framework before expanding it.
Therefore, the value of CREP would lie in whether gaining those additional credentials will translate into better patientcare without compromising the foundations of general practice.

Conclusion

My education at the University of Limerick's School of Medicine has continually reinforced the importance of placing patients at the forefront of clinical practice. Through early patient contact and problem-based learning, I have come to appreciate that becoming a competent physician requires more than developing clinical knowledge. It requires understanding the healthcare systems that shape patients' access to care and recognizing opportunities to improve them.
Ireland does not need to replicate Canada's enhanced-skills model. Instead, it can learn from both its successes and limitations to strengthen the foundations already established within Irish general practice. By aligning GP special-interest training with identified regional healthcare needs, a community-responsive framework could improve access to appropriate care and support professional development without compromising general practice care.
Returning to the patient I encountered during my Early Patient Contact Program, I recognize that enhanced GP expertise may not have eliminated their need for specialist treatment. However, having a stronger community-based pathway could have provided them with earlier assessment and greater support while they waited. I believe this program reflects an excellent opportunity to bring timely, coordinated and compassionate care to the communities that need it most.

Acknowledgement: No plagiarism or use of AI

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Commendation Winner - Sheppard Memorial Essay Competition 2025

Supporting General Practice at the Primary–Secondary Care Interface

Author: Niamh Robertson, Undergraduate, GEM 4 UCC

I declare that this work is my own without the use of AI and has not been submitted for assessment elsewhere.

A Tuesday afternoon in general practice

A man with terminal metastatic bone cancer attended afternoon clinic complaining of a new distressing abdominal pain in a dermatomal distribution, distinct from his usual bone pain. Having recently contracted shingles, he was concerned it was post-herpetic neuralgia. Despite increasing his morphine to the maximum prescribed dosage, he had not obtained adequate relief.

Before attending clinic, the patient had contacted his palliative care nurse who sought advice from the palliative care doctors. They recommended increasing his pregabalin and considering a lidocaine patch. These recommendations were relayed through the nurse to his GP. The GP requested a palliative care assessment, that they prescribe the pain relief required and initiate the process of prescribing a lidocaine patch. The palliative team could not review the patient that week. The GP accommodated the patient in a busy clinic, assessed him, identified the likely pain mechanism, increased his pregabalin and booked a follow up appointment.

I observed the work required to turn the recommendation into treatment. Both the patient and medical professionals navigated several layers of communication before the recommendation turned into treatment. The enormous coordination effort required to translate specialist advice into a concrete plan was evident. I began to question how the responsibilities arising from specialist advice are agreed and whether the general practice role is recognised and supported to implement specialist recommendations.

A recommendation is not a complete plan

This encounter raised a question extending beyond palliative care: what happens when one service makes recommendations that another service is asked to deliver? A recommendation, no matter how appropriate can leave responsibilities unresolved.

Specialist advice carries a cost in the work required to implement it, and that work can fall to general practice. The general practitioner often assumes the responsibility of turning the recommendation into an actionable plan. Recommendations can generate a series of tasks beyond writing the prescription itself, including clinical assessment, documentation, patient education, use of clinical judgement, record keeping and communication coordination. I began to appreciate the clinical and administrative work transfer from secondary to primary care in implementing a specialist recommendation.

Whenever multiple services share a patient and their care it must be agreed between them who will initiate treatment, counsel the patient, who will review and monitor the patient's progress. Those who bear the burden of these responsibilities must have the capacity to undertake them. In order to have capacity, one must be provided with the time and financial resources to fulfil this workload. The absence of such arrangements influences the quality and expedience of patient care.

The invisible workload

As a medical student, I have observed many general practitioners' clinics and noticed requests initiated in specialist care to be reissued by general practice, including GMS prescriptions, blood tests to be arranged following discharge and multiple work ups for medications. I wondered why certain tasks were being directed to general practice and the reasoning behind it. It was clear to me that the concern is not simply single recommendations but the allocation of work between primary and secondary care. I wondered whether the allocation was reflective of clinical need, agreed division of tasks or constraints from the requesting services.

The ICGP 2022 discussion paper [1], Shaping the Future, identifies transfer of secondary care work into general practice as a contributor to workload pressures. It also reports that two hours of clinical work generates one hour of administrative work. Whilst this is not specific to specialist recommendations, it highlights the extended workload beyond patient contact.

This has been described in Irish literature. In a qualitative study [2] involving 20 GPs, Hanlon and colleagues identified work transferred from other services as a contributor to administrative workload and concluded that general practice is under considerable "relentless" pressure with regards to workload which may be having downstream effects of GP workforce retention.

This is not to say the GP perspective is not beneficial to the patient or is wrongly distributed task, but benefit to the patient and increased workload coexist. A small Irish mixed-methods study [3] of direct access to diagnostic imaging found that GPs reported improved patient care in 86% of the 81 cases examined but increased workload in 58% of cases. Whilst these were subjective professional assessments in a small sample it demonstrates that evaluation of these initiatives should also include the work required to facilitate good quality care.

The core realisation here was not that the additional workload in general practice generated by recommendations is misplaced but that they hold value for the patient only to the extent that GPs can facilitate their implementation. This extends to all areas of general practice, where GPs are expected to deliver care, they need to be involved in the decision-making processes, guideline development and need to be resourced to the extent of the responsibilities agreed.

Shared care requires shared responsibility and decision making
There is an inherent benefit to the patient of shared care between specialists and a GP who arguably has the extensive knowledge of the bio-psycho-social profile of the patient. With shared care comes shared responsibility.

The Medical Council's Guide to Professional Conduct and Ethics [4] also provides a framework for shared care. It acknowledges "the movement of patients within and between primary, secondary and tertiary care has the potential to be high risk" but simultaneously acknowledges that it is in the "best interests of the patient that the overall management of their care is under the supervision and guidance of a general practitioner". It also advises that when transferring care through handover or return to primary care that actions required of primary care should be documented.

The guidance acknowledges the essential contribution of GPs whilst recognising the risks of shared care. It does not however, establish which team should assess and prescribe. It does highlight the necessity for clear communication and agreement about responsibility clinicians expected to deliver a pathway should help design its responsibilities and support arrangements. Clear communication between all parties is a crucial element to providing the right care but should involve assessing the receiving practice's capacity to undertake it.

A Scottish qualitative study [5] aimed to assess the implications of shared responsibility on patient care. They identified that perceived inappropriate transfer of workload and resistance to this transfer along with unrealistic expectations of what their colleagues could achieve were major areas of improvement that have a direct implication on patient care. A similar Irish study [6] recognised the same issues, but Irish GPs described feeling that they currently bear a disproportionate share of the responsibility. They were asked to recommend solutions. They reported that care resources such as IT systems, liaison staff, and integrated care committees could be potential solutions but acknowledged fair distribution as a key solution.

This study demonstrates that whilst mutual understanding can help determine how work is allocated, it cannot do so alone. Decisions should be informed by assessment of the clinical input and resources required rather than subjective opinions of the respective primary and secondary care capacity. As such, explicit agreements regarding the distributions of tasks could

be justified. However, it is of utmost importance that GPs have a meaningful contribution to discussions.

The cost to patients
Whilst I could see firsthand the professional workload, burnout potential and interdisciplinary disagreements, the patient suffers too. This patient had an arduous administrative task of communicating multiple facets of his health care team whilst in pain, others have to make extra trips to a general practitioner's clinic. Unclear arrangements lead to a landslide of repeated calls, explanations, duplication of tasks and unnecessary delays in treatment all of which place a considerable burden on already unwell patients.

Gallacher and colleagues' research [7] on treatment burden such as that of a qualitative study in the UK on patients with heart failure identifies organising care and attending appointments as forms of patient work. Participants described fragmented care and inadequate communication between professionals as factors increasing that burden.

The differences between a specialist recommendation and the GP plan can be difficult for a patient to understand. Patients can experience uncertainty in their treatment. It falls to the implementer of the advice to truly take the time to explain the advice of another practitioner. Patients require a plan, a clear point of contact and follow up, some of which can get lost in translation in the transfer of work from secondary to primary care.

What meaningful support would require
Some may say that funding is the solution, whilst it is of course a massive contributor, I believe that meaningful support is multi-faceted.

Firstly, meaningful support should begin with agreement. Where advice generates further tasks, they should be divided between responsible clinicians directly. Nurse and other professionals have a very important coordination role, but the transfer of responsibility cannot be assumed simply because advice has been relayed between individuals. These specificities of these responsibilities should be agreed between practitioners in respect to prescribing, reviewing and escalating care. This requires a mutual understanding of each other's role, workload and capacity.

In practice, a mental or physical checklist when transferring work must answer four questions: who will write the prescription, who will assess the patient, who will monitor and to whom should a deterioration be escalated? This should then be documented and communicated. In the case outlined above, a simple recommendation of increase pregabalin and consider lidocaine patch does not answer these questions.

One older study by Horne et al. [8] built quality indicators from GP interviews on specialist prescribing and included requiring that the decision to share at all would be agreed by GP and hospital doctor, before a checklist is completed.

Secondly, the work needs to be resourced. To be adequately resourced, it first needs to be measured. Accurate measurement of clinical time, administrative work and clinical premises required allows us to determine what resources are required to deliver a pathway. It may reveal opportunities to simplify those administrative tasks; to streamline communication channels or it may identify work that is more appropriately completed by the recommending specialist service. It may simply identify increased workforce needs.

Financial support alone doesn't produce staff, so long term interventions may need implementing to recruit and retain GPs, including creating a pipeline of candidates from medical student to general practitioner.

Thirdly, GP involvement in these guidelines and protocols is essential. I argue that this does not mean simply inviting them to the decision-making tables but giving protected, funded participation time to facilitate contributions. Their experiences can help ensure that proposed responsibilities are realistic within general practice. Increases in funding are welcome but the core outcome must be that the resources match the extending responsibilities.

Reflections

At first, the question appeared to me to be one of who should prescribe but on reflection it is clear that a prescribing request is never just that: I came to recognise the enormous invisible clinical work, service and patient effort involved. I am clear that a specialist recommendation, prescription or otherwise is part of a wider decision as to who completes the bulk of the workload in respect to assessment, follow-up and responsibility.

It is clear to me that whilst I was seeing this from a general practice perspective another world exists for secondary care teams who have their own competing demands, capacity difficulties and limitations. However, this does not diminish the questions raised. The concern is how, in a constrained system, services can agree and respect each other's contributions whilst actively advocating for the support required to provide their respective care tasks.

Until such evaluations and commitments are made, I reflect on my own future practice. Seeking clarity and distributing tasks according to capacity will require mutual respect from both primary and secondary care physicians. This mutual respect is borne out of professional courtesy and understanding but is underpinned by a common goal of facilitating exemplary patient care. Mutual respect, however, must be supported by agreed pathways. The man I saw on a Tuesday afternoon needed relief from pain and a streamlined process along with reassurance that someone would be following his care. From these experiences it is clear, that

the work required to do this should be measured, developed with all practitioners involved and supported with the appropriate means.

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Between Two Worlds:
General Practice and the Traveller Community

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By the time she arrived twenty minutes late with three children in tow, the waiting room had already decided what kind of patient she was.

The receptionist's glance was brief but legible. A mother across the room shifted her handbag closer. The youngest child, perhaps three, pressed his face against the fish tank while his older siblings sat with the quiet stillness of children who have learned to take up as little space as possible. She gave her name at the desk without making eye contact, and when she was told the appointment had been marked as a Did Not Attend, she did not argue. She simply nodded, as though she had expected it.

It was a Tuesday morning in a suburban Dublin practice, unremarkable in every way except for what it revealed. The child she had brought, her eldest, a boy of eight, had been prescribed an inhaler for asthma three months earlier. He had not returned for review. The notes read: "Did not attend x2. Non-compliant. Consider discharge letter." Somewhere between those lines, a clinical story had been written without her voice in it.

Later, when the consultation did happen, hurried, squeezed between two other patients, the details emerged not as a list of complaints but as fragments of a life. She could not read the appointment letter. The bus route had changed. Her previous GP had refused to see her youngest without a medical card, and she had not gone back. She did not say she had been discriminated against. She did not need to. Her caution said it for her.

For many Irish Travellers, healthcare is not entered neutrally. It is entered cautiously, if it is entered at all.

The Scale of a Crisis

Ireland's Traveller community numbers approximately 30,000 to 40,000 people, a small population carrying a disproportionate burden of illness, mortality, and exclusion.[1] The All-Ireland Traveller Health Study (AITHS), published in 2010, remains the most comprehensive examination of Traveller health ever conducted on the island.[2] Its findings were not merely concerning. They were damning.

Traveller men were found to live approximately fifteen years less than men in the settled population. For Traveller women, the gap was eleven to twelve years.[2] Infant mortality was

estimated at three to four times the national average.[2] The suicide rate among Traveller men was approximately six times higher than that of the general male population.[2,3] a figure so extreme that it resists easy contextualisation. Suicide among Irish Travellers is not merely elevated; it is catastrophic.

Chronic disease, diabetes, cardiovascular disease, respiratory illness, was significantly more prevalent.[2] Mental health difficulties, particularly depression and anxiety, were widespread, compounded by a bereavement burden that the AITHS described as pervasive.[2,4] Many Travellers reported experiencing multiple bereavements within short periods, often of young family members, often by suicide.

Perhaps most relevant to general practice, the AITHS documented widespread experiences of discrimination within healthcare settings.[2,5] Travellers reported feeling unwelcome, judged, and dismissed. Many described avoiding healthcare altogether unless a crisis forced their hand. The study made clear that these were not isolated experiences but patterns, deeply embedded, generationally transmitted, and profoundly consequential.

It is tempting to present these statistics as the core of the problem. But health inequality is often discussed statistically, and in general practice it appears one consultation at a time. The mother in the waiting room was not a data point. She was a woman trying to get her son an inhaler, navigating a system that had not been designed with her in mind and had, on more than one occasion, made her feel that she did not belong in it.

Engagement with healthcare cannot be separated from generations of exclusion, discrimination, and institutional mistrust.[5,6] To frame poor attendance or late presentation as non-compliance, without asking what compliance has cost, or what it requires, is to mistake absence for indifference.

Why General Practice

If the health inequalities facing Irish Travellers were purely systemic, matters of policy, funding, and infrastructure, then the response would belong to government departments and public health agencies. But much of what determines whether a Traveller patient receives adequate care happens not at the level of national strategy but in the consultation room, in the waiting area, in the six or ten or twelve minutes a GP has to listen, examine, and decide.

General practice occupies a unique position in this landscape for reasons that are structural, relational, and philosophical.

The first is continuity. In a community where institutions are frequently distrusted, where hospitals, schools, and social services have historically been experienced as sites of judgment or exclusion, the GP may become the only consistent healthcare relationship a patient holds.

This is not a minor detail. Continuity of care has been shown, across multiple studies and populations, to improve health outcomes, increase patient satisfaction, and reduce emergency presentations.[7,8] For Traveller patients, whose engagement with healthcare is often fragmented by mobility, literacy barriers, and previous negative experiences, continuity is not merely beneficial. It is foundational. In communities where institutions are distrusted, continuity becomes a form of medicine.

The second is context. Hospital medicine, by necessity, often sees disease in isolation, a presentation, a diagnosis, a discharge. General practice sees lives. The GP who knows a Traveller family over time comes to understand not only their medical histories but their housing instability, their grief, their children's school difficulties, their experience of discrimination, their reasons for silence. This contextual knowledge is not supplementary to clinical care. It is clinical care.[9] The GP consultation is one of the few places where medicine still has the opportunity to know a person before knowing their diagnosis.

The third is the challenge of preventive medicine. Screening uptake, vaccination rates, chronic disease management, and early presentation are all lower among Traveller populations.[2,10] These are not failures of individual motivation. They are failures of a system that has not earned the trust required for prevention to work. Prevention, after all, asks patients to engage with healthcare before they feel unwell, an act of faith in a system that, for many Travellers, has given little reason for faith. The GP who understands this does not simply offer another appointment. They offer a reason to come back.

Trust, Bias, and the Architecture of Care

There is a moment in medical training when one learns to recognise the "difficult patient." The term is never formally taught, but it is absorbed, through corridor conversations, through the way a file is handed over with a raised eyebrow, through the subtle shift in tone when a name appears on the morning list. It is one of medicine's quieter lessons: that some patients are easier to care for than others, and that the reasons for this are rarely examined.

Implicit bias in healthcare is well documented.[11,12] It affects consultation length, diagnostic reasoning, pain management, referral patterns, and the language used in clinical notes. It is rarely dramatic. More often, it is cumulative, shorter consultations, reduced curiosity, lowered expectations. A Traveller patient who presents frequently may be labelled as anxious or attention-seeking. One who presents late may be labelled as careless. One who misses appointments may be labelled as non-compliant. In each case, the label closes a door that curiosity might have opened.

This is not an accusation directed at individual clinicians. The vast majority of GPs enter the profession with a genuine commitment to equitable care. But bias does not require malice. It requires only haste, fatigue, and the unexamined assumptions that accumulate in any system

under pressure.[11] The ten-minute consultation, already insufficient for complexity, becomes even more constrained when cultural distance is added, when the patient's frame of reference, health beliefs, family structure, or communication style does not align with the clinician's expectations.

The concept of cultural safety, developed originally in New Zealand in the context of Māori health, offers a useful framework here.[13] It differs from cultural competence, which implies that a clinician can learn enough about another culture to navigate it effectively, by shifting the focus inward. Cultural safety asks not, "What do I know about this patient's culture?" but "What assumptions am I bringing to this consultation, and how might they affect the care I provide?"[13,14] It is a more demanding question, and a more honest one.

In the context of Traveller healthcare, cultural safety means recognizing that a patient's reluctance to disclose, to attend, or to follow a management plan may not reflect ignorance or apathy but a rational response to historical and ongoing exclusion.[5,6] It means understanding that trust is not a given but a clinical achievement, something built slowly, through consistency, respect, and the willingness to remain present even when engagement is difficult.

Trust is not an accessory to healthcare. In general practice, it is infrastructure.[8,15] Without it, prescriptions go unfilled, referrals go unattended, and screening invitations go unopened. With it, the consultation becomes something more than a transaction. It becomes a relationship, imperfect, sometimes frustrating, but capable of bearing the weight of illness, grief, and vulnerability.

Medical training often frames communication as primarily about clarity, the right words, the right structure, the right explanation. Increasingly, it seems that communication is less about clarity than about humility: the willingness to listen before treating, to ask before assuming, and to accept that the patient's experience of healthcare may be radically different from the clinician's intention.

What Traveller Care Teaches Us About Medicine

It would be convenient to treat Traveller health as a niche topic, a matter of social inclusion, relevant to public health but peripheral to the daily work of general practice. But this would be a misreading. The challenges that arise in caring for Traveller patients are not exotic. They are amplified versions of challenges that run through all of general practice: the patient who does not attend, the family in crisis, the chronic disease that worsens because the system moved too quickly for the person inside it.

Caring for marginalized communities reveals what medicine is supposed to be.[16] It demands patience when the system rewards speed. It requires continuity when funding models favour throughput. It asks for curiosity about lives that are easy to stereotype and difficult to

understand. It insists on advocacy, not as a political act, but as a clinical one, because a patient whose housing is unstable or whose literacy is limited cannot benefit from a management plan designed for someone whose life is orderly.[9,16]

The greatest barriers to healthcare are not always geographic or financial. Sometimes they are relational. A patient who mistrusts healthcare is not irrational if healthcare has repeatedly failed them. A community that disengages from screening is not indifferent to health if screening has never been offered in a way that felt safe.[5,10] These are not excuses. They are explanations, and in general practice, explanations matter, because they change what happens next.

Traveller healthcare, in this sense, is not a special interest. It is a mirror. It reflects back the values that general practice claims to hold, holism, continuity, equity, patient-centredness, and asks whether they are practised or merely professed. It exposes the gap between the medicine we aspire to and the medicine we deliver when time is short, resources are scarce, and the patient in front of us does not fit the template.

Returning to the Waiting Room

The boy with asthma did come back. Not because the system worked, but because his mother decided to try again, a decision that required more courage than most clinicians will ever appreciate. His inhaler technique was reviewed. A spacer was provided. A follow-up was arranged at a time that accounted for the bus route. These were small adjustments, unremarkable in isolation, but they required something that medicine does not always prioritise: the willingness to adapt the system to the patient, rather than expecting the patient to adapt to the system.

There was no dramatic turning point. No moment of revelation. Just a quiet recalibration, a recognition that the consultation had not failed because she arrived late, but because the system had never made arriving easy.

Between two worlds, settled and Traveller, institution and individual, doctor and patient, general practice still has the rare ability to build a bridge slowly enough for trust to cross it. This is not efficient medicine. It is not scalable. It will not appear in a performance metric or a quality indicator. But it may be the most important thing general practice does: remaining present where trust has been hardest to build, and believing that presence, over time, is enough to begin.

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Clinical acumen in learning disability: improving diagnostic acuity and red flag recognition in the GP setting.

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Introduction

General practitioners (GPs) play an integral role in the provision of global and inclusive healthcare in the primary care setting (O'Dowd, Ivers and Handy, 2018). General practitioners in Ireland undertake 29 million consultations per annum (Collins and Homeniuk, 2021). Those consultations will include patients with a learning disability. It is estimated that rates of general disability (inclusive of hidden conditions, sensory and physical issues) are 23% of people aged 20-69 years old in Northern Ireland (NI) and 22% in the Republic of Ireland (Economic and Social Research Institute (ESRI), 2026). Disability includes intellectual, specific learning difficulties and cognitive disabilities. It has also previously been reported in 2020 by Disability Action that 1 in 5 of the NI population have a disability.

As the population of people with learning disabilities exceed their life expectancy, they become more likely to develop illnesses such as cancer and other life limiting conditions (Tuffrey-Wijne et al., 2016). A red flag is an indicator of a serious health concern; GPs have the provision to expedite these referrals to secondary care. It has been reported that diagnostic inaccuracy has occurred with patients with mental health conditions and learning disabilities (Heslop et al., 2013; Liberati et al., 2025). Diagnostic overshadowing was first recognised in people with psychiatric disorders, whereby their physical illness was overlooked or misattributed to their mental health condition (Reiss et al., 1982). This work addresses the risk of clinical oversight with this patient cohort and reflects on the systems and processes that are in place to ensure early detection and subsequent red flag referrals, via the correct pathways (Northern Ireland Cancer Network (NICaN), 2024; Health Service Executive, 2026).

Background

The contemporary definition of diagnostic overshadowing is "the tendency to attribute all behavioural, emotional, physical and social issues to a person's learning disability or a pre-existing condition, while overlooking the possibility that they could be symptoms of other conditions or difficulties." (National Institute for Health and Care Excellence (NICE), 2018).

Historically, people with learning disabilities have been subject to this diagnostic overshadowing, meaning their symptoms were not assigned to advanced disease, with poor

overall access to health screening and red flag referrals to secondary care (Reiss et al, 1982; Tuffrey-Wijne et al., 2016; National Institute of Clinical Excellence (NICE), 2018; Dell'Armo and Tassé, 2024; Local Government Association, 2025). Red flag pathways allow patients with suspected cancer to access specialists urgently, within a defined limit of time (Northern Ireland Cancer Network (NICaN), 2024; Belfast Health and Social Care Trust, 2026).

Red flag referrals account for approximately 34.4% of Cancers that are diagnosed (except non melanoma cancers of the skin). Patients also have a greater survival rate at one year through a GP referral (87.6%) as opposed to direct hospital attendance via the emergency department (42%) (Queen's University Belfast Northern Ireland Cancer Registry (NICR), 2026). Within those cohorts sit the vulnerable population of people with learning disabilities. Statistics may not be a true representation due to those with learning disabilities being hidden from services altogether, or having missed red flags.

People with learning disabilities have poorer health outcomes due to diagnostic delays, oversight and trouble identifying health needs (Heslop et al., 2013). The Confidential Inquiry into the Premature Deaths of People with a Learning Disability (CIPOLD) highlighted that both women and men die roughly 20 and 13 years younger respectively, than those without learning disabilities (Heslop et al., 2013).

A recent UK population-based cohort study of people with learning disabilities found that certain cancers were more common, including testicular cancer (twice as common), central nervous system cancers (3.5 times as common) and uterine at the highest in comparison (70% more common). Cancer was often incurable by the late stage it was diagnosed. Sadly, most died sooner after diagnosis than their nondisabled counterparts, at four years compared to nine (Kennedy et al., 2025).

Challenges

In a GP setting, communication difficulties can impede upon the ability to establish rapport with patients with learning disabilities, and foster trust. Particularly within the time constraints allotted for consultations. Behaviours may be misunderstood, and red flags missed (Local Government Association, 2025). This can unintentionally result in reduced diagnostic acuity and overshadowing, with a failure to employ the same principles that would be applied to red flag refer or diagnose the general population (General Medical Council (GMC), 2026). Similarly, this can happen with mental illness and as learning disabilities often present with co morbid mental illness, there is therefore a danger that this may compound any healthcare bias, making identification of red flags more challenging (Hallyburton, 2022). Dell'Armo and Tassé (2024) reviewed studies demonstrating that this overshadowing bias led to diagnostic inequalities, however more research was suggested to support this assertion

The patient themselves or their carers may also have poor awareness of what to look out for in respect to red flag symptoms, leading to late presentation to primary care and late

presentation of the disease. As a result, there may be inequalities in diagnostic routes and cancer pathways, with later access to treatments and poorer outcomes (Wiering et al., 2026).However, family and carers of people with learning disabilities advocate for the person and become their voice, as they often have expertise in caring for their loved one and know them best. This includes knowing what is normal for their baseline, how they communicate pain and what is abnormal for them. The CIPOLD inquiry highlighted the systemic barriers that people with learning disabilities encounter with carer expertise often dismissed, and the family seen as 'difficult' (Heslop et al., 2013).

There has been some progress in primary care in England for patients in general, with the advent of Jess's rule for GPs, when referrals may have been missed. Repeat visits, in this case 3, should prompt a GP to 'reflect, review and rethink.' Although this rule is not operational in Ireland, the framework and ethos of this rule should be considered and integrated into practice where feasible (National Health Service (NHS) England, 2025). Implementation of frameworks such as this has been recognised as critical for people with vulnerabilities such as learning disabilities.

Since COVID, there are mounting pressures for GPs, exacerbated by waiting lists and with patients living longer with more complex health needs. Challenges such as these have led to nearly 1 in 3 practices in Northern Ireland seeking assistance from the General Practice Improvement and Crisis response team (www.picrt.co,uk) (Northern Ireland Audit Office, 2023). This may have an impact on accessibility of GPs, which has a knock-on effect for patients with learning disabilities.

Recommendations

People with learning disabilities can face issues with care navigation once inside the healthcare system. (Wiering et al., 2026). To address this, it is important that healthcare providers and the government provide education and information on red flags that is adapted and tailored to people with learning disabilities and the GPs that refer them; to improve awareness on how symptoms might present differently in this population of people.

Suggestions to improve red flag referrals and reduce diagnostic overshadowing include involving the family caregiver(s) to ensure documentation of the person's baseline and their communication needs and methods. Reasonable adjustments should be made where feasible and documentation completed accurately, including the persons health care passport. Importantly, staff in General Practice should have mandatory training on the interplay of learning disability, diagnostic overshadowing and red flag referrals.

Where possible the family may elect for a familiar Doctor who knows their loved one well. It would be good continuity of care if the person was linked to a particular GP, provided this is reasonable within the restraints of the practice, including staffing. Similarly, where possible, longer consultations would allow for adaptations and communication adjustments, Family

members should be recognised translators who can interpret communication and behaviours (Kirkendall et al., 2017). Repeated visits should also be considered an indicator that further investigation is warranted.

Conclusion

Through this discourse analysis it is clear there is potential for a percentage of people with learning disabilities to get missed when it comes to red flag referrals from primary care. There are some efforts to address and acknowledge the potential for diagnostic overshadowing when it comes to primary care consultations with people with learning disabilities and their carers. However, this needs to be integrated at macro level within our systems and at a micro level at clinical point of care, at the coal face. This is also important when it comes to the prevention of negligent omission(s), as law firms are now pursuing accountability in civil litigation lawsuits.

Reasonable goals of better identification of symptoms and more urgent referrals will ensure improved diagnostics and timely treatments. Otherwise, healthcare providers and systems simply contribute to a system that minimises the lives and life expectancies of people with learning disabilities. Existing initiatives in England such as Jess's rule show the tide may be turning, and if similar safety schemes are employed across the Island of Ireland in future, it can ease the burden of missed red flags and lates diagnoses on both the GPs and the patients. Primary care and secondary care go hand in hand and are important continuity of care for people with learning disabilities, both have responsibilities when it comes to joined up working, to ensure people with learning disabilities with red flag symptoms do not get left behind.

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The Missing Measurement: Heavy Menstrual Bleeding in General Practice

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Niamh had been changing her pad six or seven times a day. She had already tried the postpartum-style diaper pads some women use after birth, hoping the extra absorbency would give her some relief, but even that had not been enough. She described all of this clearly and without prompting. The GP listened, properly and attentively, and asked appropriate follow-up questions; this is not an account of a doctor who failed to listen. She offered to fit a coil, advised iron supplementation, and reached into the drawer for the model Mirena kept there for exactly this conversation. "This is what it looks like," she said, "it lasts five years for the bleeding, and up to seven if you also want it for contraception." Niamh nodded along, visibly relieved to have a plan.

I watched the whole exchange and thought, at the time, that this was what good general practice looked like: a patient describing real suffering clearly, and a doctor responding with warmth and a workable plan. It was only afterwards, writing up the notes, that I noticed what had not happened. No one had scored her bleeding against anything more concrete than six or seven pad changes a day. No one had mentioned tranexamic acid, the pill, or any option besides the coil. No one had examined her, or referred her to gynaecology or haematology to establish what was actually causing this, rather than simply treating the symptom in front of us. No one had asked whether she still hoped to have children. She had been offered the one option that happened to be nearest to hand, and she accepted it gladly, carefully explained and kindly delivered, but entirely unexamined.

I did not think much of it at the time. It was only the third or fourth time I watched some version of the same sequence that I began to notice it as a pattern rather than a single appointment.

The Treatment Came Before the Assessment

Once I had noticed it, I could not stop seeing it. Different GPs, different practices, the same shape: a patient describing real, specific suffering, listened to attentively, and a clinician who moved directly to treatment without the assessment that should have preceded it. I want to be precise about what kind of failure this is, because it would be easy to characterise it as a failure to listen, and every consultation I observed demonstrates the opposite. These were clinicians who listened well. What was absent was not attention. It was that no one had ever been taught, as a matter of routine, to reach for a PBAC score the way one reaches for a

stethoscope, or to treat the exclusion of an underlying cause as a step that precedes symptom management rather than one that follows it, if it occurs at all. This is a training gap, not a compassion gap, and the distinction matters, because it determines what actually needs to be addressed.

A second clarification is equally necessary, this is not an account of a passive patient either. Every consultation I observed concluded with both parties satisfied, a plan agreed, the patient's described suffering taken seriously, and a doctor who was thorough about the matter actually discussed. This is precisely what makes the pattern difficult to name. Nothing about any individual appointment appeared wrong. It was only the repetition that prompted me to ask what was missing rather than what was present.

When a Pattern Becomes a System

After the third occurrence, I sought out the relevant guideline, both to test my own instinct and to establish whether I was identifying a problem that did not, in fact, exist. The National Institute for Health and Care Excellence guideline NG88 on heavy menstrual bleeding, the guideline to which the ICGP's own Quick Reference Guide on contraception management directs GPs, proved far more specific about the sequence of assessment than I had anticipated[1]. A physical examination is required before investigations or before an LNG-IUS is fitted, not as a procedural formality but because it is the means by which secondary structural causes are excluded before a treatment decision is made. The guideline organises this around a framework known as PALM-COEIN: polyp, adenomyosis, leiomyoma, malignancy or hyperplasia, coagulopathy, ovulatory dysfunction, endometrial, iatrogenic, and not-yet-classified. A submucosal fibroid or an endometrial polyp can produce a bleeding pattern indistinguishable, from the patient's own description, from ordinary heavy periods[1]. The only way to differentiate the two is to examine, not to listen more attentively.

What I found more striking was what the guideline specifies clinicians should not routinely do. Serum ferritin and hormone testing are not recommended by default for uncomplicated HMB, which suggests the failure I had observed was not simple under-investigation. It was over-testing in one direction, where bloods are sent reflexively elsewhere in general practice, and under-examination in another, where neither the bimanual, the speculum, nor the differential is considered before treatment begins. One further line struck me as directly relevant to Niamh: NG88 states that management should follow the woman's own priorities[1]. That requirement means something only if she is offered something against which to weigh her priorities. Niamh was not a patient who arrived requesting a coil and received one; she described her suffering, and a coil was the only option presented in response. She accepted it gladly, and I do not doubt it was the right choice for her. However, gladly accepting an option is not the same as choosing among several, and no guideline's insistence on shared decision-making can function within a conversation that offers only one option to be glad about.

None of this renders the coil the wrong choice; it remains correctly first-line, alongside tranexamic acid, NSAIDs, and the combined pill. My concern is narrower than "wrong treatment." A good treatment was substituted for an assessment, by both parties, through a mutual and entirely understandable default. That is not the same failure as prescribing incorrectly. It is a failure of sequence, and it matters because general practice's central claim to being able to help a patient rests on sequence: on not requiring a patient to already know what is wrong with her before she can be properly assessed.

The Number Behind "Heavy"

I returned to the library that week largely to settle my own doubt: was "it feels heavy" genuinely an inadequate basis for a treatment decision, or was I overanalysing a reasonable clinical shortcut? What I found was more unsettling than I had expected. Higham and colleagues' original 1990 validation study of the Pictorial Blood Assessment Chart (PBAC) found that a score above 100 corresponded to a measured blood loss above 80mL, with 86% sensitivity and 89% specificity.[2] This is a strong instrument. A more recent study, directly comparing patients' own perceptions of their bleeding against objectively measured loss, found a correlation of only $r = 0.23$.[3] I read that figure twice before accepting it. It means that how heavy a woman believes her bleeding to be explains barely five percent of the variance in how heavy it actually is, close to no relationship at all, and yet "it feels heavy" is precisely what I had watched stand in for assessment in every one of those consultations.

I do not believe this means patients should not be believed. I believe it means we are asking them, and ourselves, to perform a task that a two-minute chart already performs better. PBAC scoring requires neither a blood draw nor a delay. A separate study comparing it against alkaline haematin, the laboratory reference standard, found a Spearman correlation of 0.600, with an area under the curve of 0.796 at a cutoff of 150; pooled validation studies more broadly report sensitivity ranging from 58–98% and specificity from 7.5–97%, depending on the chart version and cutoff applied.[4,5] That range is wide enough to warrant honesty rather than overstatement: no single cutoff performs identically across every population in which it has been trialled. However, the relevant comparison is not "PBAC versus a perfect test". It is "PBAC versus no structured tool whatsoever," which was the actual comparison taking place in every room I observed. A test that is correct most of the time, with known limitations at its margins, is preferable to a conversation containing no measurement at all. The instrument that would have closed most of the gap between "feels heavy" and "is heavy" already existed. It fits on a single sheet of paper, it would have taken less time than the conversation about the coil itself. No one reached for it.

When Ten Minutes Determines the Consultation

I asked one of the GPs about this directly, expecting to be told that the examination had simply been forgotten. She told me, without hesitation, that the coil was the most effective treatment available, and that patients presenting with heavy bleeding are usually already looking for a solution rather than a work-up. Appointments at her practice, she added, had been reduced from fifteen minutes to ten over recent years, and on days when she covered for colleagues, it was sometimes closer to five. She was not complaining about any individual patient. She was describing an arithmetic she lived inside every day, and her own reasoning, efficacy first, assessment if there is time left over, was the pattern I had been trying to name stated back to me in a single sentence.

I did not take this on faith alone. An Irish observational study of routine consultations found that publicly-entitled patients had a median consultation length of 12.5 minutes covering two problems, and privately-insured patients 14 minutes covering three; consultations addressing more problems were longer, but not substantially so.[6] A UK study on the same question is more direct still: patients raise an average of 2.5 concerns per consultation, 41% of consultations involve three or more, and each additional problem raised extends the consultation by only around two minutes.[7] Two minutes does not accommodate a bimanual examination, a PALM-COEIN differential, a PBAC score, and a genuine conversation about fertility and preference, in addition to whatever else the patient came to discuss, and few patients come to discuss only one matter.

Niamh, as it happened, had not presented with her bleeding alone. She had mentioned it fourth or fifth on a list that also included a repeat prescription, a rash, and a question about her daughter's asthma inhaler. A ten-minute slot, already reduced by everything else on that list, met a presentation with an obvious, guideline-approved answer sitting one drawer away. Faced with that arithmetic, it is understandable to prioritise the part of the consultation that produces a visible outcome, a plan, a device, a sense of something having been accomplished, and to defer the part that, most of the time, produces nothing to report. I do not have a satisfactory resolution to this. I am not suggesting that greater awareness dissolves a structural time pressure that every GP I have spoken with already understands, in their own terms, better than I do. What I return to is that this is precisely the situation general practice is intended to accommodate: holding an undifferentiated presentation responsibly, within a short consultation, without requiring the patient to arrive already knowing what is wrong with her. That undertaking depends on continuity and relationship performing some of the work that time cannot. But it also depends on the examination actually taking place, and on more being offered than the single option that happened to be closest to hand, and I am no longer certain that undertaking survives contact with a five or ten minute slot as often as it should.

A Measurement Gap Begins in Medical Education

Part of the explanation, I believe, precedes any individual consultation. The World Health Organization has identified menstrual blood loss measurement itself as a neglected global health research priority, and the average diagnostic delay for HMB is estimated at approximately six years.[1] Six years is not an abstraction. It represents six years in which a woman has, in most cases, already told more than one clinician that something is wrong, and been offered treatment for the symptom before anyone confirmed its cause. When the underlying measurement science has been under-resourced for this long, it is unsurprising that PBAC has not become reflexive practice; it was never incorporated into my own teaching with the weight given to, for instance, blood pressure technique. Blood pressure is measured at every visit, by a nurse, before the GP enters the room, because decades of investment made this routine. Menstrual blood loss has received no equivalent investment, and consequently has no equivalent routine. No one I observed had failed to apply something they had been taught. The gap in the consultation room is downstream of a longer-standing gap in what has been considered worth measuring precisely, and worth teaching as routine, in women's health.

Three Changes That Could Close the Gap

I do not wish to conclude on aspiration alone, so here are three specific proposals, none of which require new funding, a new guideline, or additional time in a slot that has none to spare. First, a nurse-led PBAC score taken at check-in for anyone presenting with heavy bleeding, in the same way blood pressure is already taken before the GP enters the room, so that the figure exists before the consultation begins, rather than depending on the GP finding two minutes in which to request it. Second, a brief, plainly-written leaflet on HMB in the waiting room and on the practice website, naming tranexamic acid, NSAIDs, the pill, and the coil in a sentence each, so that the option nearest to hand within a rushed ten minutes no longer becomes, by default, the only option either party considers. Third, a single prompt built into the electronic health record that appears before an LNG-IUS order for HMB is finalised, asking whether an examination and a differential have been documented, not as a hard stop, but as a checkbox that renders the missing step visible rather than silent.

What I find valuable in all three proposals is that none requires the GP to accomplish more within a slot that is already too short. Each asks the check-in process, the waiting room, or the record system to contribute a little more, so that by the time doctor and patient are face to face, the option on the table is already an informed one, and the figure that should have prompted a proper assessment is already present in the chart. This is a modest ambition. I believe it is also the only kind worth proposing within a system in which the ten minutes, or the five, are not returning.

When One Option Becomes the Only Option

Niamh was never asked about children. She was never told that anything besides the coil existed. She was not, in the end, even asked; she was offered it, and she said yes, because it was the only thing on the table and it sounded like relief.

I still do not know whether examining her that day would have changed anything. Perhaps her bleeding was exactly what it appeared to be, and the coil was always the correct answer. Perhaps it was not, and I will never establish which, because the chart will simply record that a plan was offered and gladly accepted. What I do know is that no one, not the GP, not the system surrounding the GP, not I, watching and saying nothing, ever widened the question sufficiently to find out.

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The Consultation That Disappears

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"Will my GP be informed?" The question appears in the Department of Health's public information on the Common Conditions Service (CCS). Its answer begins "Where appropriate".[1] The HSE's professional FAQ is more explicit: routine notification of the GP is not legally required after a consultation.[2] Neither statement means that pharmacists fail to communicate. Together, however, they leave a clinical question inside an administrative phrase: what makes an encounter worth remembering elsewhere?

Ireland has deliberately made it possible for some consultations to finish without a GP appointment. That is an achievement worth protecting. Removing an appointment need not remove useful information from the patient's later care. A prescription can be entirely appropriate today and relevant to a different decision months later. The difficulty is to preserve that future usefulness without making the GP inspect every episode of care that the reform has successfully moved elsewhere.

Consider the Irish cystitis protocol. It excludes pharmacist prescribing under that protocol when there has already been one urinary tract infection (UTI) in the preceding six months, or two in the preceding twelve months. Pharmacists must ask about previous episodes.[3] Its safety boundary depends on a history extending beyond the consultation it authorises.

At the service's January 2026 launch, the Department reported more than 1,800 pharmacies had signed up.[4] Eight conditions are covered, including allergic rhinitis, shingles and uncomplicated lower urinary tract infection. Trained pharmacists assess patients within national protocols, document decisions and provide safety-netting; referral is an appropriate outcome outside those boundaries.[5] This is a clinical encounter, not simply a new route to buying a medicine.

Those boundaries deserve respect in both directions. A pharmacist should not need a GP's retrospective blessing for a decision properly made within the protocol. Equally, the GP who later sees persisting symptoms needs to understand what has already been tried. Professional autonomy is compatible with both propositions. Indeed, information that accurately attributes

a decision to its maker may protect autonomy better than a vague account of treatment obtained elsewhere.

The service's stated purpose includes releasing GP appointments for more complex needs.[1] Whether an individual pharmacy visit replaces a GP visit cannot be assumed, but the intention is sensible. General practice cannot defend continuity by insisting on providing every encounter. A patient whose cold sore resolves after pharmacy care has no obligation to return to the surgery simply to keep its record complete. Continuity should help people live beyond healthcare, rather than make healthcare harder to leave.

The difficulty appears when an apparently complete episode acquires a second meaning. Symptoms recur, or never quite resolve. Nothing about the first assessment need have been wrong. Its significance has changed because time has supplied another piece of information. At the next GP consultation, the question extends beyond which treatment to try: does this still belong in the category of illness in which it first arrived? General practice needs the earlier assessment both to use it and, when necessary, to reconsider it.

Haggerty and colleagues distinguished informational, management and relational continuity more than two decades ago.[6] A familiar GP can be unaware of a pharmacy prescription; an unfamiliar clinician can use a reliable account of it. An electronic record cannot reproduce the knowledge built through a relationship. It can, however, stop a change of provider from requiring a fresh start in the clinical history.

Nor is longitudinal knowledge the GP's exclusive possession. A regular community pharmacist may recognise changes that nobody in the surgery has seen. Information must travel towards the clinician making the next relevant decision, who may also be a pharmacist. Improving the GP's view while leaving the pharmacy dependent on incomplete history would preserve a professional hierarchy rather than continuity. The patient's account remains essential. It should not also have to perform every transfer between them. This matters especially when someone is already unwell enough to need another assessment: the act of seeking help should not carry an additional test of how accurately they remember a previous clinician's terminology.

Return to the cystitis exclusion. It asks a sound question about the past; the information system must help clinicians answer it. An earlier episode may have been managed appropriately, resolved completely and required no GP action. Its date can nevertheless change eligibility when symptoms return. A first episode must remain findable if the second is

to be recognised as a second. Waiting until recurrence is identified before deciding that a record deserves to travel would miss the very information needed to identify it.

The protocol also directs patients whose symptoms fail to improve within 48 hours of starting treatment to seek advice from a GP or another relevant medical practitioner.[3] At that assessment, the prescription and its timing matter, but so does whether symptoms ever settled. Three visits may describe three infections or one unresolved problem. The protocol itself warns that recurrent urinary symptoms may have other causes.[3] For the patient still experiencing pain, having that distinction understood matters more than whether every encounter has acquired a code.

HSE operational guidance already requires a substantial record of assessment, relevant history, medicines, decisions and safety-netting.[5] The challenge is therefore not simply to tell pharmacists to write more. Information can be accurately recorded yet unavailable where it acquires new importance. Conversely, absence from the GP record does not establish absence from care: patients may explain what happened, and clinicians may communicate directly. Published rules cannot tell us how often those routes succeed.

England supplies a useful warning against confusing transmission with usefulness. Pharmacy First requires notification to the patient's general practice on the same or following working day.[7] In a 2026 OpenSAFELY study of records from practices using TPP software, Kingsley and colleagues found that, by January 2025, 36.3% of recorded Pharmacy First consultations contained a structured clinical condition, medication, or both.[8] This is a finding about coded content within recorded consultations. It is not the proportion of all consultations communicated successfully. The authors could not determine what information GPs could actually see; clinical content might exist in correspondence or free text.

Knowing that an encounter occurred differs from retrieving its clinical meaning. A transferred document may support a consultation while remaining difficult to search across time. The English study cannot establish Irish harm. It supports testing what a subsequent clinician can actually use, rather than assuming that either sending information or storing it guarantees continuity.

At this point, the obvious remedy is to send everything to the GP. It is also where the argument should hesitate. Every successfully treated cold sore does not require another doctor to read it. A stream of routine reports may force a practice to decide, repeatedly, whether

somebody has asked it to do something. If releasing an appointment creates an indefinite obligation to review care elsewhere, some of the work has merely changed its address.

In a US Veterans Affairs survey, primary-care practitioners' perceived information overload was associated with reporting missed results that delayed care.[9] The study was cross-sectional and relied on self-report; it cannot demonstrate that additional pharmacy messages would cause missed results here. The reported number of alerts itself was not associated with either missed-result outcome. The lesson concerns manageable work and usable systems, not a proven numerical ceiling on messages.

A second objection is harder. If tomorrow determines what today's episode means, selective memory risks discarding something prematurely. An unremarkable consultation may become important for a reason no designer anticipated. Four decisions must be kept separate: retaining the source record; making it retrievable later; placing a notification before another clinician; and requesting action. A record can survive without being accessible, and a notification can demand attention without explaining what action is needed. Selectivity belongs principally in the claim on attention, not in erasing the past.

This principle is already reflected in English policy. NHS England's 2024 GP Connect guidance distinguishes consultation summaries from actions or referrals, permits automatic filing, and retains pharmacists' responsibility for their treatment decisions.[10] Ireland need not invent that distinction. It needs to apply it to a service whose own eligibility rules make yesterday's otherwise settled consultation relevant today.

Cystitis offers a bounded place to test it. A concise shared summary could identify the encounter and clinician, record the presenting problem and assessment, and include treatment details, with the source record available for context. These are proposed fields, not a validated national dataset. A prescription-only feed would miss advice and referrals. A record of suspected cystitis must also retain that uncertainty: a searchable history that converts suspicion into confirmed diagnosis could mislead more efficiently than disconnected records do.

Counting entries would not be enough. Several consultations may belong to one unresolved episode; treating each as a separate infection would manufacture recurrence. Follow-ups should be linked where that relationship is known, with uncertainty visible where it is not. A prescription records an intention to treat, not proof that medicine was dispensed or taken. The

summary should improve the questions asked at the next consultation, rather than answer them prematurely.

Action needs a different route. A request for further assessment should specify the concern, urgency and intended recipient, with the patient clear about how to obtain care. An urgent referral cannot depend on somebody choosing to browse a shared record. Agreed arrangements must cover failed communication and unavailable appointments. Merely labelling a message for information would not absolve a clinician who actually encounters a significant concern. The distinction requires workable responsibilities, not a disclaimer attached to a document.

The patient also has a stake in where information travels. Someone seeking treatment for vaginal thrush may reasonably question wider visibility. The HSE FAQ requires consent to sharing to be documented and addresses exceptional disclosure where serious harm is at issue.[2] Patients need a clear account of recipients and purpose, proportionate access controls and a way to correct inaccuracies. A patient-held summary offers additional support without making its holder responsible for every transfer.

For someone without an established GP, sending information to the usual doctor is not a continuity plan. An authorised clinician at the next encounter should be able to retrieve it. Yet no shared record will be complete. A blank history must never be mistaken for evidence that nothing happened.

The HSE Shared Care Record offers a possible route. It provides a read-only view of information including reimbursement-scheme medication details and GP-requested investigations. Its public description currently limits access to trained HSE staff on the HEALTHIRL network and does not list a comprehensive CCS consultation feed.[11] That is a limit of the published description, not proof that no local exchange exists. Ireland cannot assume that every GP and pharmacist can already open a common timeline.

A dataset can exist nationally and still be inaccessible to the person deciding what to do next. Community access within ordinary consultations requires funding and agreement. Meanwhile, a concise patient-accessible encounter summary, identifying the pharmacy and assessment, could support direct communication when further care is needed. Its reliability should be measured, and any digital version must have an accessible alternative. A future record cannot carry a present clinical responsibility.

The legal position requires equal precision. The Health Information Act 2026 provides for a duty to share and electronic health records. Its July commencement order brought selected provisions into operation on 17 August, but did not include section 7, the duty-to-share provision.[12,13] Legislation is not evidence of a functioning CCS information route. Similarly, changes enabling electronic pharmacy record-keeping from 30 June 2026 depend on compliant software and do not themselves provide access for other clinicians.[14] Permission to store and a useful clinical exchange are different accomplishments.

Evaluation should follow the information into its next use. Ali and colleagues' Irish modified Delphi study identified important CCS outcomes including symptom improvement, referral and reconsultation with other providers, while highlighting difficulties measuring outcomes through existing data.[15] Within that framework, Ireland could ask a narrower question: when later care makes an earlier CCS assessment relevant, can the clinician reconstruct it accurately enough to apply the protocol?

A pilot involving pharmacies and general practices could compare information available at subsequent consultations with the original pharmacy records and the patient's account. It should include relevant encounters that never became visible, rather than count only messages that arrived. Independent review could assess whether the information appropriately changed a decision. Better retrieval alone would not establish safer care; outcomes and unintended consequences would still need evaluation.

There is a cost even to quiet information. Finding and interpreting it consumes consultation time, and somebody must create a reliable summary. A pilot should measure that work in both settings, alongside unnecessary reviews and duplicate episodes. Appropriate escalation must not be labelled failure simply because the patient subsequently sees a GP. If the summary adds work without improving care, its design should change or the proposal should be abandoned. Continuity is too valuable to be defended by an untestable claim that more of it must always help.

Ireland's fee structure adds a further qualification. Patients pay the CCS consultation fee even if they hold a medical card.[1] Evaluation must therefore distinguish service users from people whose choice of provider is constrained by price. A record can help explain care received. It cannot reveal the needs of everyone who could not afford to enter the service.

The opening question now needs two answers. Whether the GP needs to act today depends on the clinical problem and an explicit handover. Whether an encounter will matter later cannot always be decided when it ends. General practice must be able to recognise a changing pattern without being required to supervise every episode that contributes to it.

"Where appropriate" should become a standard examined at the next consultation. The earlier episode should be recoverable when it changes care, without obliging a second clinician to repeat work already completed well. An uneventful first episode needs no retrospective drama. It needs to be findable if another follows. The patient should be able to leave the pharmacy with the episode settled. What Ireland must preserve is the possibility of recognising it again, if time gives it a different meaning.

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An Unremarkable Examination: Gender, Pain and the Burden of Being Believed

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There is a peculiar vulnerability in being asked to prove something that only you can feel. Pain has no universal language, no objective scale capable of capturing its full complexity, and no obligation to make itself visible. Yet modern medicine, for all its sophistication, remains deeply attached to what can be measured. We investigate, image, and examine, searching for evidence that might explain the suffering described before us. When such evidence is found, a patient's account acquires legitimacy. When it is absent, uncertainty emerges. Too often, that uncertainty extends beyond the diagnosis to the credibility of the person describing it.

I have experienced this uncertainty from both sides of the consultation room.

At fourteen, I was diagnosed with complex regional pain syndrome following spinal surgery. Eight years later, as a final-year medical student, I am learning to recognise disease in others while continuing to navigate chronic pain myself. These two identities have given me an unusual perspective on the relationship between clinical evidence and lived experience. I understand diagnostic reasoning, treatment limitations, and psychological adaptation. I also understand what it feels like when the severity of one's suffering is not reflected in the findings of an examination.

As a young woman, I have become particularly conscious of the expectations surrounding how illness should look, how pain should be expressed and how much suffering a person must demonstrate before it is taken seriously. My experience raises a question that extends far beyond chronic pain: when medicine cannot explain a patient's symptoms, why does the patient so often become responsible for proving that they are real?

This question is particularly relevant to general practice, where illness often precedes diagnosis. GPs must balance diagnostic vigilance with the risks of over-investigation, often without immediate access to specialist resources. Their responsibility extends beyond identifying disease to preserving trust when an explanation remains elusive.

The Limits of Objectivity

Medicine has progressed enormously through objective evidence. Investigations identify previously invisible pathology, while evidence-based practice protects patients from ineffective interventions. Objectivity is among medicine's greatest strengths.

The difficulty arises when objective findings become the sole measure of a patient's experience.
Pain is inherently subjective. The International Association for the Study of Pain defines it as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. Its revised definition acknowledges that pain is a distinct phenomenon and that a person's report of pain should be respected.[1] The implication is profound: pain does not require visible tissue damage to be legitimate.

Yet clinical encounters can communicate a different message.
Normal investigations may appear to provide an answer, when for the patient they represent only the beginning of another question: If nothing is wrong, why do I still feel this way?

Negative investigations are valuable. They can exclude serious pathology, guide management, and provide reassurance. But there is a fundamental difference between reassuring someone that a particular disease has not been identified and suggesting that their symptoms are therefore less significant. I have often reflected on the phrase *unremarkable on examination*. It is clinically useful, concise and familiar to anyone who has written medical notes. Yet it captures only what was observable at a particular moment. It cannot convey the hours of interrupted sleep preceding an appointment, the activities abandoned because of pain or the effort required to appear outwardly well.

An examination may be unremarkable. A person's experience may be anything but.

The Credibility Gap
Philosopher Miranda Fricker introduced the concept of epistemic injustice to describe situations in which individuals are wronged in their capacity as knowers.[2] One form, testimonial injustice, occurs when prejudice leads a listener to assign less credibility to someone's account than it deserves. In
medicine, it explains how patients can feel disbelieved without explicit accusations of exaggera tion.

The credibility gap may appear through subtle interactions: a symptom attributed prematurely to anxiety, an explanation dismissed because investigations are normal, or a patient whose apparent composure is interpreted as evidence that their suffering cannot be severe. Such judgments need not arise from deliberate cruelty. Clinicians may believe they are practising appropriately by avoiding unnecessary investigations or encouraging psychological coping strategies.

I have never felt that I fulfilled the conventional image of someone living with significant illness. I am young, outwardly capable, and able to participate in medical school. I can hold a conversation, laugh with friends, and appear entirely comfortable while experiencing pain that infiltrates every aspect of my life. There is an uncomfortable paradox in this. The better I become at living with pain, the less visible that pain becomes to others.
The strategies enabling me to function also obscure my suffering.

For women, this paradox may be compounded by conflicting expectations surrounding emotional expression. Samulowitz and colleagues, in a literature review examining gendered norms in chronic pain care, identified recurring stereotypes associating women's pain with emotional or psychological explanations, while men's pain was more often understood through biomedical frameworks.[3]
The review draws attention to important patterns, although its findings should not be interpreted as evidence that every difference in pain management arises from discrimination. Variations in presentation, diagnostic complexity and healthcare access also influence clinical decisions. Nevertheless, the persistence of gendered stereotypes raises questions about whether apparently objective assessments are always free from unconscious expectations.

Women can find themselves navigating a peculiar double bind. Express too much distress, and their symptoms risk being interpreted as emotional. Remain composed, and the apparent absence of distress may be taken as evidence that their suffering is manageable.

Too emotional to be considered objective; too composed to be considered unwell.

These expectations are not exclusive to women, but they expose a contradiction in how medicine sometimes interprets the performance of illness. Such judgments are especially problematic in chronic illness, where adaptation is often essential. Functioning despite pain should not be mistaken for functioning without it.

The Problem with Being Told to Cope
Some of my most formative experiences of healthcare occurred during adolescence, when I was beginning to understand that pain might become a lasting part of my life.
I remember being encouraged to read books exploring the relationship between the mind, body and illness, including Bessel van der Kolk's *The Body Keeps the Score* and Monty Lyman's *The Painful Truth*. Both approach suffering through different lenses, offering insights into how the nervous system, experience and perception influence our understanding of pain.
The intention was presumably constructive: to help me understand the complexity of chronic pain and develop a healthier relationship with it.
Looking back, I recognise the value of this approach. Chronic pain requires more than pharmacological treatment. Psychological support and acceptance can help patients reclaim aspects of their lives threatened by illness. My understanding has developed through experience, psychological support and studying medicine.
But at fourteen, that advice felt different.

I was still trying to comprehend why my body hurt, why my life had changed and why the pain persisted after the original pathology had been treated. Before I felt that my experience had been fully acknowledged, I was being encouraged to reconsider my relationship with it. What might have been intended as empowerment felt, at the time, like dismissal.

Psychological approaches to pain are not inherently invalidating; they are often essential components of effective care. The problem is not necessarily what is offered, but when and how.

There is a difference between telling a patient, "Your pain is real, and we can explore ways to help you live alongside it," and leaving them with the impression that their suffering persists because they have not yet learned to think about it differently.
The former acknowledges pain before inviting adaptation. The latter risks transferring responsibility for unresolved suffering onto the person experiencing it.

Contemporary guidance on chronic primary pain recognises the potential benefits of approaches such as acceptance and commitment therapy and cognitive behavioural therapy.[4] Evidence supporting psychological interventions should not be interpreted as suggesting that persistent pain is imaginary, or that patients are responsible for failing to overcome it.

For adolescent patients, the distinction between being offered support and feeling dismissed may be particularly important. Adolescence is a period of developing identity and independence, when illness can disrupt not only physical functioning but the imagined shape of one's future.
Encouraging resilience is important, but resilience should not become another standard patients are expected to meet.

At fourteen, I did not need someone to promise that my pain would disappear. I needed someone to recognise what it had already taken from me before asking me to build a life around it. The lesson I take from this experience is not that clinicians should avoid difficult conversations about acceptance. Rather, acceptance should be an invitation, not a demand, and acknowledgement should precede it.

When Women's Pain Becomes Normal
The credibility gap becomes particularly consequential when suffering is normalised by the very society in which it occurs.

Endometriosis provides a striking example. Painful menstruation is common, but when severe symptoms are interpreted as an expected part of womanhood, the boundary between normal physiology and pathology becomes dangerously blurred. Repeated reassurance may lead patients to question whether their experiences warrant medical attention at all.

In October 2026, an RTÉ Investigates survey gathered responses from almost 1,800 women about their experiences of endometriosis care in Ireland. Among respondents reporting a diagnosis, the average time to diagnosis was 14.5 years, while 88% reported waiting at least five years. More than half of those who reported a previous misdiagnosis said their symptoms had been attributed to normal menstrual pain.[5]

These findings are striking but require careful interpretation. Participation was voluntary, meaning women with particularly difficult experiences may have been more likely to respond. The reported average cannot therefore be assumed to represent diagnostic delays across the entire Irish population. Nevertheless, the survey provides valuable insight into the experiences of women whose suffering preceded recognition by years.

Perhaps most troubling is the possibility that repeated reassurance may not simply delay diagnosis, but teach patients to distrust their own bodies.

In October 2025, Ireland introduced its first National Framework for the Management of Endometriosis.[6] Central to the framework is a model of presumed diagnosis, enabling treatment and referral based on symptoms without requiring definitive surgical confirmation. Its accompanying government announcement explicitly recognised women as reliable narrators of their own symptoms and pain. This represents a meaningful shift in the relationship between clinical evidence and patient testimony. Rather than requiring women to wait for pathology to be demonstrated before their symptoms acquire legitimacy, the framework recognises that their accounts can provide sufficient grounds for clinical action.

For GPs, this has practical implications. Recognising persistent pelvic pain as potentially pathological, initiating appropriate treatment, and arranging referral when indicated can all occur before definitive confirmation of endometriosis. The GP's role is therefore not simply to identify which patients warrant specialist investigation, but to prevent diagnostic uncertainty from becoming therapeutic inaction.

Yet policy alone cannot eliminate the credibility gap.

In Northern Ireland, access to specialist services presents additional challenges. A 2024 Assembly response reported a routine outpatient waiting time of ten months for Belfast Trust's endometriosis clinic, while some other trusts reported longer waits for general gynaecology assessment.[7] These figures concern service access rather than the total interval between symptom onset and diagnosis, but illustrate the barriers facing women seeking specialist care.

Such delays cannot be attributed solely to disbelief. Service capacity, diagnostic complexity and referral pathways all contribute. Nevertheless, when access to investigation is limited, the quality of the initial clinical encounter becomes even more important.
A GP may be unable to offer an immediate diagnosis or specialist appointment. They can, however, ensure that uncertainty does not become dismissal.

The lesson extends beyond gynaecology: the absence of demonstrable pathology does not diminish the significance of pain.

General Practice: The Value of Being Known
GP occupies an unusual position in medicine. Unlike specialties organised around particular organs or diseases, it encounters illness before it has necessarily acquired a name. Patients arrive with experiences rather than diagnoses: pain, uncertainty, fear.

Across Ireland, GPs must navigate these presentations within the realities of appointment pressures, referral delays and finite healthcare resources. They must distinguish symptoms requiring urgent investigation from those that can be managed conservatively, while

recognising that a reassuring initial assessment does not necessarily end the patient's experience of illness.
General practice can both perpetuate and challenge this gap.

A hospital investigation offers a snapshot. Longitudinal primary care can offer a narrative.
A GP who knows a patient over time may recognise changes that would be invisible within a single encounter: gradual withdrawal from activities, repeated disruption of employment, or the emotional cost of symptoms that have resisted explanation.
Evidence supports the importance of sustained relationships. A systematic review by Pereira Gray and colleagues identified an association between greater continuity of care and lower mortality.[8] However, the observational nature of much of the underlying evidence limits conclusions about causation. Nor does an association with mortality establish that continuity directly improves the experience of patients with chronic pain.

Nevertheless, continuity offers something especially relevant to diagnostic uncertainty: the opportunity to develop an understanding of a patient's illness that extends beyond isolated findings.
For patients with chronic pain, it may also reduce the exhausting requirement to repeatedly reconstruct and defend their experiences.

I have come to appreciate how much trust can depend on seemingly small choices of language.
A GP who says, "I cannot yet explain why this is happening, but I can see how much it is affecting you," offers something fundamentally different from one who simply reports that investigations are normal.
The first response preserves uncertainty without withdrawing credibility. It also creates space for shared decision-making. Management can be guided not only by symptom scores or examination findings, but by what matters most to the individual: sleeping through the night, maintaining relationships or returning to an activity they value.

These outcomes may be difficult to capture in a clinical record, but they are central to the experience of illness.

In this respect, believing a patient is not merely an expression of compassion. It is a practical component of good clinical care.

Belief Is Not the Opposite of Clinical Judgement
There is a danger in framing the solution as simply believing every patient without question. Medicine requires critical evaluation. Symptoms can have multiple explanations, and inappropriate investigations or treatments can cause harm.

The responsibility of a good clinician is not to accept every proposed diagnosis. It is to take the reported experience seriously while remaining appropriately uncertain about its cause.
The biopsychosocial model challenges the separation of disease from the individual experiencing it.[9]

For me, its value lies in recognising that pain can be simultaneously physical, emotionally consequential and socially disruptive. These dimensions do not compete for legitimacy. The danger arises when the model becomes unbalanced: when psychological factors are explored only after physical investigations are unrevealing, or when psychosocial interventions are presented as substitutes for continued clinical curiosity.

Studying medicine has changed how I understand the consultations I experienced as a teenager. I now appreciate the difficulty of treating chronic pain, the limitations of available interventions and the emotional burden clinicians may experience when they cannot offer a cure. Advice I once interpreted as dismissive may have been offered with genuine compassion and sound clinical reasoning.

But understanding the clinician's perspective has not erased the patient's.

Instead, it has made me more attentive to the gap that can exist between intention and impact.
I cannot know whether my age or gender influenced the way my pain was interpreted. Nor would it be fair to reduce every difficult clinical encounter to prejudice. Yet my experience has made me conscious of how easily patients can be judged against an imagined version of illness.

I do not want my experience to make me a doctor who assumes every patient shares my understanding of pain, or who allows personal experience to replace clinical judgement. I hope, instead, that it makes me more comfortable acknowledging what medicine cannot always explain.

Good general practice requires a willingness to resist premature explanations, review symptoms as circumstances change and admit uncertainty without abandoning the patient. A patient's need to be believed is not necessarily a request for agreement about the cause of their symptoms. Sometimes it is simply a request for their suffering not to be placed on trial.

Conclusion: Beyond the Unremarkable
At fourteen, I was encouraged to read books that might help me understand my pain. At the time, I wanted something different. I wanted someone else to understand it first.

Eight years later, I can appreciate what those books were trying to teach me. They explore how pain is more complex than the relationship between injury and sensation and how our experiences and bodies are intertwined. Their ideas now resonate with my understanding of illness in ways they could not when I was younger.

But perhaps the most important lesson was never contained within their pages. It was that understanding pain and acknowledging suffering are not the same thing.

Modern medicine has become increasingly sophisticated in its ability to detect disease, yet the experience of illness continues to exceed what investigations can demonstrate. For patients

with invisible conditions, this creates a burden beyond the symptoms themselves: the burden of making suffering credible.

For women, that burden may be compounded by expectations surrounding emotional expression, resilience and the normalisation of pain. Ireland's evolving approach to endometriosis offers an opportunity to reconsider these assumptions, recognising that the patient's account is not merely supplementary to clinical evidence but can be an essential part of it.

GP is uniquely positioned to lead this change. Through continuity, clinical curiosity and a willingness to tolerate uncertainty, GPs can recognise suffering without abandoning scientific rigour.
My experience of chronic pain has taught me that being believed does not require a clinician to have every answer. It requires a willingness to acknowledge the reality of suffering even when its explanation remains incomplete.

An unremarkable examination may be an accurate description of clinical findings. It should never become a verdict on the person being examined. Perhaps, before we ask patients to change their relationship with pain, we must first examine our own relationship with believing them.

Declaration
This submitted work is original and contains no plagiarism or use of AI.

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Is Plain Language Always Enough?

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“Hi, I'm Bella. What brings you in today?”
For a young doctor, this might seem like an entirely normal way to begin a consult. It’s friendly, conversational, and intended to put the patient at ease. But imagine the patient sitting opposite the young doctor is an 85-year-old woman who has spent most of her life addressing doctors by their professional titles. She might appreciate the warmth of the introduction or she might find it unexpectedly informal. Perhaps she wonders whether Bella is the doctor or another member of the healthcare team. Meanwhile, Bella, believing she has created an approachable atmosphere, may have no idea that her introduction has been interpreted differently.

Neither person has misunderstood the words themselves. The misunderstanding lies in the meaning attached to them.

As medical students, we spend years learning a new language. We rapidly acquire a vocabulary that allows us to describe diseases precisely and communicate efficiently with colleagues. Yet when we enter the consult room, we encounter patients whose understanding of illness has been developed through experiences that are far removed from our textbooks. We are taught to replace medical terminology with plain language, but removing the jargon does not necessarily mean that the person listening understands what we are trying to communicate.

There is also a second, less obvious barrier: the language of generations. Two people may speak the same language while attaching entirely different meanings to words, expressions, and behaviours. Nowhere are these barriers more important than in general practice, where communication is not simply about one appointment, but about developing a relationship that may last decades.

Of course, these are not the only factors that influence how we communicate. Gender, culture, religion, and racial identity also shape how patients understand illness, interact with doctors, and interpret what is said to them. These influences often overlap, making communication far more complex than just choosing the right words. While each deserves consideration, this essay focuses on two barriers that can be particularly easy to overlook: medical terminology and generational differences.

The First Barrier: Speaking Medicine

One of the challenges of medical education is that as our clinical vocabulary expands, our everyday language can become increasingly unfamiliar to the people we are training to care for.

Words such as ‘benign’, ‘idiopathic’, ‘chronic’, and ‘negative’ become part of our daily vocabulary. Within medicine, each has a specific meaning, but outside medicine these words may carry entirely different associations.

Consider a patient who is told that an investigation has returned as a negative result. To the doctor, this may be reassuring. To the patient, who associates the word negative with something undesirable, it may create uncertainty. Similarly, explaining that a condition is chronic may be clinically accurate, but what does chronic mean to the person receiving the diagnosis? Will it last forever? Will it progressively worsen? Will they still be able to work and/or care for their family? The clinical definition of a term is not necessarily the information a that patient needs.

The Health Service Executive's National Healthcare Communication Programme recognises effective communication as a skill requiring practice, reflection, and self-awareness [1]. Clear explanations and checking patient understanding are basic components of good clinical communication. Yet this raises a further question: is plain language always enough?

A doctor might replace hypertension with high blood pressure, believing they have successfully translated medical terminology into everyday, accessible language. Yet a patient who feels entirely well may still struggle to understand why they need the medication. They understand the words, but perhaps not the significance of the diagnosis.

There is a difference between simplifying language and simplifying meaning. The former makes medical information accessible and the latter risks overlooking the patient's concerns and the personal significance of illness. Rather than simply asking whether patients understand us, we must ask what they have understood and what that information means to them.

Even when doctors communicate without jargon another obstacle remains. Patients bring their own language, beliefs, and experiences into the consultation, shaped partly by the generations in which they have lived.

The Second Barrier: The Language of Generations

Imagine an older patient attending her GP because she has been feeling “a bit off” for several weeks. She explains that she is not herself but cannot identify anything in particular that is

wrong. When asked about her mood, she insists she is fine. When asked whether she feels anxious or depressed, she dismisses the suggestion. She is simply not herself.

For a young doctor who is used to structured history-taking, this description may be frustratingly vague. Yet for this patient, “not myself” might be the most accurate description available for her experience. It may encompass fatigue, grief, loneliness, and/or physical discomfort, none of which she necessarily considers as separate medical problem.

The difficulty may not be that the patient lacks the vocabulary to explain herself, but that the doctor has not yet learned how to interpret it.

In 1978, Kleinman, Eisenberg and Good explored how patients' understandings of illness are shaped by their cultural and social experiences [2]. Their work distinguished between disease as understood through biomedical knowledge and illness as experienced by individuals. Although these differences are frequently discussed in relation to culture, they are equally useful when considering generational experiences.

A patient who grew up when emotional distress wasn’t discussed openly may describe their struggles differently from someone raised in an environment where conversations about mental health are common, even encouraged. One patient might readily identify feelings of anxiety, while another reports poor sleep, exhaustion, or persistent physical discomfort.

Stigma can further complicate these conversations. A young doctor may regard the word depression as a neutral clinical term, while an older patient may associate it with shame, weakness, or a loss of independence. The doctor believes they have asked a straightforward question, but the patient may hear something entirely different.

Of course, age does not determine a person's beliefs or communication preferences. Not every older patient values formality or avoids discussing mental health, just as not every younger patient is comfortable with contemporary language. Nevertheless, our experiences influence the meanings we attach to words. The challenge is not to develop a different script for each generation, but to recognise that our own interpretation may not be shared by the person sitting opposite us.

When the Consult Begins Before the Medicine

These differences extend beyond how patients describe illness. They also influence how we establish the doctor–patient relationship. Consider again the seemingly simple introduction: “Hi, I'm Bella. What brings you in today?”

For some patients, this may create an approachable atmosphere and reduce the traditional hierarchy between doctor and patient. For others, particularly those accustomed to addressing doctors in a formal manner, it might create uncertainty about professional roles or boundaries.

Would “Good morning, I'm Dr. Sweeney” be more appropriate? Maybe. But for a younger patient who values a more informal relationship, it might introduce unnecessary distance. Neither approach is inherently better. The difficulty arises when we assume that our intended meaning is the same meaning the patient receives.

The evolving language of identity offers another example. A young doctor might introduce herself by saying, “Hi, I'm Bella, and I use she/her pronouns.” For some patients, this communicates openness and inclusion while others may be unfamiliar with the terminology or be uncertain about its relevance to their appointment.

This does not mean inclusive language should be abandoned when it is unfamiliar. Rather, it highlights the need to communicate respectfully without assuming everyone shares the same vocabulary or experiences.

Perhaps the more important question is not how we believe doctors should introduce themselves, but how the patient wishes to be addressed and what makes them feel most comfortable.

Professionalism is not synonymous with formality, just as friendliness is not a substitute for familiarity. A doctor can maintain professional boundaries while remaining warm and approachable. The skill lies in recognising how patients respond and being able to adapt accordingly.

These seemingly small interactions reveal something important: that communication begins long before the diagnosis or treatment plan. It begins with establishing a relationship in which both parties feel comfortable expressing themselves.

General Practice: Learning Each Other's Language

General practice is uniquely positioned to navigate these barriers because communication is rarely limited to a single appointment. A GP may care for the same patient across decades, witnessing changes in their health, independence, family circumstances, and understanding of illness. Over time, doctor and patient may develop a shared language that extends beyond medical terminology.

A longstanding GP might recognise that a normally cheerful patient describing herself as “a little tired” is expressing something more significant than just typical fatigue. Another patient

may regularly minimise symptoms, while someone else uses dramatic language to describe a relatively minor discomfort. Familiarity provides a context that may be difficult to establish during a single consult.

This importance of continuity is supported by research. In a 2018 systematic review, Pereira Gray and colleagues found that 18 of 22 included studies reported a statistically significant association between a greater continuity of doctor care and reduced mortality [3]. Although these observational findings cannot establish causation, they highlight the potential importance of a sustained therapeutic relationship. For young doctors entering general practice, this presents both an opportunity and a challenge.

Our medical education supplies us with a consult frameworks, communication techniques, and clinical knowledge. Yet it cannot teach us the individual meanings that patients attach to their experiences. These can only be discovered through listening, curiosity, and repeated encounters.

Continuity allows this understanding to develop, but familiarity must not become complacency. Knowing a patient for many years does not guarantee understanding them. Their beliefs, circumstances, and priorities may change with time, just as our own language and expectations may also evolve. Perhaps this is where the true value of general practice lies. It offers opportunities not simply to explain medicine more clearly, but to understand what illness means to each patient.

A patient may understand the risks of hypertension perfectly well yet still prioritise avoiding medication that interferes with daily life. Another may understand a diagnosis of depression, but fear what it means for their independence or relationships. Shared decision-making requires more than just presenting options in accessible language, it requires understanding what a patients values and how those values shape their interpretations and opinions.

In this sense, communication is not merely the transmission of information from doctor to patient. It is a process of negotiation, interpretation, and mutual understanding.

Conclusion: Beyond the Words

As medical students, we spend years learning to speak the language of medicine. But perhaps an equally important part of becoming a doctor is learning that can language fails us. Removing medical jargon addresses one barrier to communication. Recognising that patients may attach different meanings to everyday words, expressions, and behaviours can addresses another. Generational differences can make these challenges particularly visible, but ultimately every patient brings an individual history that shapes their understanding of medicine and illness.

The seemingly simple choice between introducing ourselves as “Bella” or “Dr. Sweeney” illustrates how even familiar words can carry unfamiliar meanings. General practice offers something particularly valuable: the time and continuity to discover those meanings. Through curiosity, adaptability, and good listening, doctors and patients can gradually develop a language that they both understand.

Perhaps the most important communication skill for a young GP is not knowing exactly what to say, but to recognise when to ask what a patient has understood. Because speaking the same language doesn't always mean we're having the same conversation. The “art” of general practice may lie in recognising the difference.

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The Informed Patient: Does AI Change their Demands?

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It's morning in a GP clinic; the patient list is full, and each patient has different needs, concerns, and expectations. The GP goes about their consultations, doing what they can for each patient. Patient A came in because of a spot around their toe. They mentioned nerves because they had seen a video that really scared them into coming to the GP, and they brought the TikTok with them as evidence. When the doctor initially told me about the patient's history and reviewed the note about why this consultation was happening, I was curious as to what this was going to be. The note left by A just said concerning spot on toenail. I was curious what this would be: was this an infection, or was it a fungal nail, or what was this lesion?

The next patient comes in for a general health check. While going through what brings them in, Patient B mentions they want to lose weight. They have seen loads of information online and were looking up their options online. They want a GLP prescription, but is this their best option?

Patient C comes in to renew their prescription. They had a history of hypercholesterolemia and had been taking statins. When patient C began their consultation, they mentioned they have had too many side effects and didn't feel right. They were experiencing myopathy, which they were aware could occur, but it had begun affecting their ability to move around and enjoy their daily activities. They had looked some information up and wanted to investigate switching their medication.

A pattern emerges. Patients arrive with information and clear expectations of the appointment. Is this the modern patient? Has wider access to health information changed what patients expect from their GP, and does AI change this relationship further? Patient expectations are not new. A 1977 study of the doctor–patient relationship noted that the literature of the time focused on the doctor's expectations of the patient, particularly compliance, yet patients already came to primary care with expectations of their own [1]. They stated that at this time the literature was focused on the doctor's expectations of the patient, especially regarding patient compliance. Patients already came to primary care with expectations of physicians and healthcare [1]. This paper established that patient expectations are an old primary care issue present from before the age of the internet.

Then came the age of Google, where patients now had even more access to health information. The influence of health information seeking is dependent on whether the patient discusses the information with the doctor and what the prior relationship was like [2]. Despite obtaining health information independently, the patient expectation allows for a shared

decision to be made between physician and patient. Physician responses to patients bringing information into consultations ranged from defensiveness to collaboration, with some directing patients to more reliable information [2]. The patient role became more active and participatory, expecting patients to be engaged in their health decisions. Patients reported that the information gap is reduced and report greater control, confidence, and empowerment. Over time, this doctor patient relationship has evolved into the shared decision making model. The process now includes patients and health care providers collaborating to make decisions based on the latest evidence and patient preference [3].

Differences between Google searches and AI based health information seeking were explored by Wardle et al. AI provides conversational answers to questions and asks to follow up questions to personalize the answer [4]. Patients here can use the information to make healthcare decisions. AI changes how information is obtained and processed. They found that the patient would ask a personalized question, and the search engine would give a synthesized conversational response [4]. After which it was the patient's choice to use that information to guide their next action, explore treatments, referrals, and medications [5]. AI health information was associated with making decisions about whether to seek professional care, help explore treatments, request referrals [5]. How is AI searching different from the old Dr. Google, and how AI has affected this already murky patient doctor relationship?

Lian et al., reported that the highly engaged modern patient still often defer to clinical authority at the final stage [6]. Then Ayo-Ajibola studied how AI-generated information was already influencing appointments, medications and care-seeking, while questions remain about accuracy [5]. They argue clinicians may increasingly need to help patients use and interpret AI-generated health information safely. Though a percentage of people did request referrals or changed medication, 67.9% suspected some information could be inaccurate and 67.5% consulted a physician to verify and discuss information [5]. Further a systemic review found that despite positive perceptions, users of AI acknowledge certain risks of bias which needs to be addressed [9]. Two other studies showed that it is important for the GP to be able to identify the relevance of the information provided to guide the shared decision. They stated that the SDM process is still essential and should remain because despite the usefulness of AI in informing the patient, they continue to expect their health care provider to retain final discretion over treatment and monitoring their care [3]. Similarly, a cross-sectional study found that AI is influencing how patients are now seeking care and the type of care they are looking for [5]. Both studies indicate that it is important how the provider allows the information to change the consultation. So maybe the future GP evolves the way they interpret, contextualize and apply information along with clinical assessment to the individual patient.

These challenges have affected the whole world as time progresses, but how are these expectations negotiated in the Irish context? In 2019 O'Doherty et al showed that GPs described feeling pressure to prescribe antibiotics even when they recognized inappropriate antibiotic use, and according to the interviews, GPs acknowledged unnecessary prescribing

and described circumstances where perceived pressure contributed to antibiotic prescribing [7]. This issue was multipronged with system factors contributing to this dynamic, the private patients, out of hours care and other factors. The Irish studies primarily capture GP perceptions rather than directly measuring patient expectations [8]. GPs described either accommodating preferences, compromising, delaying escalation, or eventually arranging imaging and/or referrals. Some said resisting a strongly preferred intervention consumed considerable time and energy. Both studies reported the GP's perception of their patients' expectations; neither directly establishes what the patients expected [7, 8]. Further evidence suggests that AI was perceived by both patients and clinicians as aids in clinical care. It would be a tool to "promote patient engagement and communication with their clinicians, increase patient confidence and compliance, inform the consenting process, present risk estimates in an interactive and individualized manner, and improve patient satisfaction," [9]. If international research shows patients can be highly engaged while deferring to physician authority, then maybe an informed and questioning patient shouldn't be interpreted as demanding.

Patient A had come in with a set of concerns, during the consultation they had shown the GP a video that led to them booking the appointment and they wanted to know if GP agrees. When patient A left the room, they had received a referral to the dermatology lesion clinic. Patient B left the consultation with a link to GLP information and a commitment to improve their lifestyle before a follow up to re-evaluate the need for the prescription. And Patient C got their medication switched from the statin due to adverse effects.

Was this just to please the patient? Or why did this occur? I began asking questions. The GP informed me that this patient obviously came in with their concerns and although the GP was not sure. From the GP's experience it's best to evaluate the concern to be able to give reasons why the concern is or isn't present. So, in this case, upon inspection of the toe the GP found clinical signs present making the lesion referrable. With patient B that GP said their approach with this young and healthy patient was to encourage lifestyle changes before starting that way they get most of the drug should they choose to. And Patient C, the GP said that adverse effects are a justifiable reason to switch drugs and there were a few others they could try in this case.

Seeing these consultations firsthand was a great learning opportunity to see different communication styles and tools used. These consultations showed me that a patient's initial request does not alone determine management. Clinical assessment and informed discussion lead to a shared decision. Physician expertise remains essential, but the form it takes within the consultation is evolving.

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Never smoked, now addicted. The next generation of nicotine in Ireland.

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COPD doesn't exist in Clontarf...
What a ridiculous and untrue thing to come out with, and yet it's what I told people in college when they asked me how I was getting on with GP placement. Context is everything.

During a meeting with a medical sales rep, my GP tutor remarked that COPD was very uncommon among the practice population, something that she attributed to the low prevalence of smoking in the area. Later that same day, we discussed this matter which had been puzzling me. COPD is something that we learn to death in med school, so perhaps somewhat naively, I had always assumed it was uniformly common everywhere. It got me thinking: why this particular area? Were decades of anti-smoking campaigns and public policy the key to this success or was it down to the population's socioeconomic composition? The reality likely found between the two. The conversation developed and my tutor pointed out that while she sees relatively few smokers, vaping was becoming increasingly common among her younger patients. Cigarettes might have gone out of fashion, but nicotine certainly had not.

Later on in the week, a college event run by one of the medical societies took place and I decided out of curiosity to count up how many people I saw vaping. As the night progressed and ultimately ended in a nightclub, I had long since lost count. Someone would pull a vape from their pocket and you could follow it as it was passed around from person to person, each 'bumming' a puff from its owner. What was remarkable was how unremarkable someone producing a vape had become. Offering someone a pull felt as ordinary as offering someone a drink. As I started planning this essay, naturally, I started to notice vaping all around me. On every bus, at every traffic light, on social media, in restaurants and pubs, and even in the library, people were vaping everywhere! I was humming and hawing about what I wanted to write about, then came the nail in the coffin. Scrolling TikTok one night, I came across a video by Grammy Award winning artist Lola Young. She was opening up about her vaping addiction and described how her lungs felt "battery powered" and that breathing felt "like a chore". How had we gotten to this point? How did a generation that, by and large, rejected cigarettes, end up addicted to nicotine anyway? end up addicted to nicotine anyway?

Use of e-cigarettes among 15 to 24 year olds in Ireland rose from 1% in 2015 to 18% in 2023, while 13% of 12 to 17 year olds reported currently using them in 2022 (Evans et al. 2026). This is particularly striking when compared with the population as a whole, with 8% currently using

e-cigarettes according to the CSO. Vaping is no longer for middle-aged ex-smokers who are trading cigarettes for e-cigarettes, and it hasn't been this way for quite some time. Vaping has established itself as a distinct part of youth culture. In fact, vaping has become so prominent that young people are entering the world of nicotine through vapes, never having lit a cigarette. Traditionally, nicotine dependence was created by trying a cigarette, followed by the occasional cigarette socially, which lead to regular smoking and later dependence. Nicotine has crept back into society following a similar pipeline of trying someone else's vape, occasionally vaping in the social context, then subsequently buying your own vape and thus regular vaping.

Hence, a new route for nicotine dependence was born. These innocent puffs being 'bummed' in the nightclub turned out to be much more problematic than intended. Nicotine dependence can no longer be assumed to have begun with smoking cigarettes. This isn't the only mechanism by which vapes made their way into young people's lives. Fun and alluring flavours, disposable devices, concealability at home and during school, peer pressure and social media have all contributed to the rise of e-cigarettes. In contrast, the traditional smoking of cigarettes has garnered a generation worth of stigma; they smell, require going outside, carry intense health warnings on their packaging and are seen as the single worst thing you can do to your body. Vaping on the other hand, has managed to escape all this and remains largely socially acceptable. All these factors together have created a new type of patient seen in general practice, the teenager who is addicted to nicotine but has never smoked.

But vaping isn't nearly as harmful as smoking, so what's the issue? In this, there is no denying. McNeill et al. (2022) concluded that vaping poses "only a small fraction of the risk of smoking", and for an established smoker, this relative reduction in harm is clinically important. However, the problem arises when we focus on the comparative risk between vaping and traditional cigarette use, rather than the absolute risk of vapes themselves. In fact, in instances where clinicians believed vapes were safer alternatives to cigarettes, they were less likely to initiate discussion with patients about vaping (Baker et al. 2026). Nevertheless, the scenario is flipped upside down when the patient is a never smoker. The National Clinical Guideline, No. 28 on smoking cessation is clear; people who do not smoke should not start vaping. McNeill et al. (2022) reported a greater absolute exposure to potentially harmful substances from vaping compared to using no nicotine at all. Therefore, in terms of harm reduction for an established smoker, vaping versus smoking is a relevant comparison to make, but for the teenager who has never smoked before, it's vaping versus nothing.

What do we actually know about the effects of vaping? The role of a GP in this scenario should be to communicate what is known about vaping, what we might suspect about vaping, and what we genuinely do not know. In terms of the devices themselves, vapes may cause burns or explosive injury, as well as poisoning from e-liquid ingestion. The e-liquids undergo such change during the heating process that the vapour being inhaled contains toxins, volatile compounds and pro-inflammatory agents. While tobacco is absent, many compounds found in

vapes are unique to the devices (Marshall, 2025). Without producing an exhaustive list of potential harms, nicotine can have profound impacts on brain development and is highly addictive. It affects mental health, increases risk of anxiety, can disturb sleep and cause mood disorders (HSE, 2022). E-cigarette use can cause respiratory symptoms such as coughing, wheezing and dyspnoea, which have been reported to improve following cessation. In my opinion, the most important aspect of the issue is the uncertainty of the long term consequences of vaping. COPD and malignancy are diseases with long latencies and could take decades to manifest, therefore their association with vaping remains to be seen (Marshall, 2025). The absence of evidence of long term effects is not evidence of long term safety. However, this uncertainty cannot be an excuse for sensationalism and scaremongering. Telling a young person that vaping is just 'nicotine and water vapour' is a drastic understatement of what is known, while telling them that it will inevitably lead to COPD or cancer is also not supported by evidence. The truth lies between these extremes.

So, a young adult presents to the GP practice and they are a nicotine addicted, never smoker... How do you approach this? As part of our Public Health & Primary Care module in college, we are taught the 'Making Every Contact Count' approach to consultations. Within this, we learn the 5As framework, consisting of Asking, Assessing, Advising, Assisting and Arranging to guide patient behavioural change. Very interestingly, as I was researching for this essay, I came across a research paper called "Through the Haze: What Clinicians Can Do to Address Youth Vaping", where the 5A framework was applied to vaping in young people (Hadland and Chadi, 2020).

"Asking" may seem like the most obvious step in the framework, but when we zoom out, are we effectively screening patients as they turn up? Unless the patient themselves volunteer the fact that they vape, are we really asking with the intention of doing something about vaping or just trying to tick a box? Asking can also become particularly difficult when there is a parent in the room. Additionally, "Do you smoke?" is no longer sufficient. Non-smoking, nicotine-dependent individuals can confidently answer no to this question and we're still no closer to facilitating cessation. If a patient confirms e-cigarette use, it's imperative to take the issue seriously. Temptation might be to reassure that because they aren't smoking that they're grand. This is the wrong comparison to make; vaping in a never smoker should be considered its own serious issue.

While asking is an important first step, it needs to be followed by thorough assessment of the individual patient at hand. How often do they vape? What nicotine strength do they use? Whether or not vaping is the first thing they do in the morning or the last thing they do at night? Does the patient experience cravings for vapes or experience withdrawal symptoms? Most importantly, we must discover why the patient is vaping and how they became addicted? Was it a result of peer pressure, is it used as a vice to control stress and anxiety, or did it begin as a social outlet that spiralled into nicotine addiction? Finally, assessing the patient's

willingness to and attitude toward cessation is imperative. Continuing with a cessation plan for someone who may have no interest in quitting is futile. Patients may often be of the mindset that they don't have a nicotine dependence and can quit whenever they like, as discussed by Hadland and Chadi (2020). In this situation an "abstinence challenge" may be beneficial, highlighting to the patient the level of dependence that may not have been previously appreciated.

Now that an understanding for why and to what extent the patient is currently vaping, practical and appropriate advice can be given. Advice should be tailored to the individual patient and extend beyond simply "vaping is bad for you". Irish society is brilliant at telling young people not to do things, but this is of scant help to a patient who comes into a GP practice already addicted to nicotine. Regarding ex-smokers who vape, returning to traditional cigarette use would be a step in the wrong direction. Whereas for a never smoker, there is no harm reduction benefit to preserve, and the ultimate goal should be freedom from nicotine. The importance of vaping as a potential gateway to cigarette smoking should also be considered. A 2021 systematic review of high-quality studies found that teenagers aged between 13 and 19 in Europe and North America who had never smoked but had used vapes were 3.71 times more likely to subsequently start cigarette smoking compared with those who had never used vapes (O'Brien et al., 2021). However, in order to encourage patients to quit and remain nicotine free, advice must be paired with the necessary assistance to achieve cessation.

This is where the management of vaping becomes fierce difficult, as the evidence for the cessation of vaping remains far less developed than for the highly researched cessation of smoking cigarettes. Once again, a cessation plan needs to be individually tailored to the patient at hand, based on thorough assessment. Potential strategies for reducing vaping include setting a quit date to aim towards and identifying and avoiding triggers. In young people where vaping is predominantly social, avoiding certain social situations where others are vaping may be necessary. If vaping is chronic and routine, limiting access to vapes by not purchasing them or disposing of current stocks could be discussed. Distraction techniques and involving support of friends and family should also be considered (Pbert et al. 2024). While young people may be initially reluctant to disclose their vaping habits with parents, their potential to assist by supporting cessation adherence, facilitating pharmacological treatment, providing positive reinforcement and limiting access to vapes cannot be understated. Clinicians should counsel patients on the potential impacts of family involvement in the cessation process (Hadland and Chadi, 2020).

Pharmacotherapy and the use of medications have been underused in the treatment of nicotine addiction in young people. Due to the lack of research and substantial evidence, there is uncertainty over what to do with such patients, aside from counselling. While Nicotine Replacement Therapy (NRT) may be beneficial in improving abstinence from vaping, further

research is required to establish its effectiveness (Vickerman, 2024). Interestingly, one randomised controlled trial involving 261 young people who vaped but did not smoke found that continuous abstinence rates from nicotine was higher in a varenicline group with behavioural counselling, compared to a placebo group (51% vs 14% in the last month of treatment, and 28% vs 7% during a 6 month follow up). Adverse events did not differ significantly between the groups (Eden et al., 2025).

While this is an encouraging study, much more research in the area is required. It is this uncertainty that ties in the final A of the framework; arranging follow up. Vaping cessation will not be a quick fix and very few young people, if any, will be cured by a simple lecture. Nicotine dependence is relapsing and remitting, but the greater number of attempts at cessation, the higher chance there will be of success. A major barrier to opening up and discussing vaping with a GP may be the anticipated stigma and shame that a patient might be feeling. It is crucial that patients don't feel judged and are being respected (Marshall, 2025). Taking vaping seriously does not mean scaremongering or frightening a patient, it means taking nicotine addiction as seriously as any other addiction.

You might be reading this essay and be thinking of what relevance any of this is? While there is no doubt some excellent clinicians who are ahead of the pack in terms of asking about vaping habits and interventions, the reality is that the confidence in the knowledge of vaping and the use of e-cigarettes among doctors is poor. A cross-sectional survey study published in 2024 was the "first assessment of doctor knowledge" and their attitudes towards e-cigarettes in Ireland (Busher et al., 2024). They carried out a survey which received 250 responses from Irish doctors. The results showed that 84.9% of respondents reported always or often asking about smoking habits, while only 31.4% of clinicians always or often asked about vaping. 70.5% were in agreement that vaping could be a gateway to traditional cigarette use and only 23% of respondents reported feeling confident or very confident in their knowledge of e-cigarettes. How are doctors expected to counsel an addiction that they haven't even screened for, let alone advice a nicotine dependent never smoker on cessation? Clinical training, national guidelines and evidence as a whole has been centred around cigarette smoking, with vaping being thrown in as a footnote after the fact. The nicotine landscape has changed drastically over the last few decades, but has the medical society been able to keep up with it?

This essay is not just about vaping. Vapes, like cigarettes, may one day too become unfashionable. We have already seen the introduction of nicotine pouches and who knows what other products may be on the horizon. The way we consume nicotine might change, but the fundamental issue of dependence and addiction has the potential to prevail. Incredible research and progress has been made in terms of preventing smoking in young people, so much so that a generation may never light a cigarette. The challenge we now face as a community is to recognise that nicotine dependence is still alive and well and that our approach must adapt alongside the products delivering it.

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The Bet We Never Ask About

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There are questions that general practice has learnt to ask almost without realising that they are questions. A cough prompts an enquiry about smoking; an abnormal liver result leads us to alcohol; disturbed sleep brings mood, and perhaps safety, into the conversation. Over time, we have made room for subjects that are deeply personal, sometimes uncomfortable, and not always obviously connected to the complaint at hand. We ask because experience has taught us that what remains unspoken may also remain clinically invisible. Yet gambling has never quite found the same place in that familiar sequence. It may sit behind sleeplessness, financial strain or a relationship under pressure while the history proceeds around it. The bet we never ask about is, therefore, not initially the one made by the patient. It is the quieter assumption made by the clinician: that if gambling matters, the patient will tell us. But shame changes the conditions under which people disclose difficult things, and silence cannot always be taken as evidence of absence. This does not mean that every consultation needs another questionnaire. Rather, it raises a more uncomfortable question about our existing histories: when gambling is clinically relevant, what makes us decide that it is not worth asking?

Before answering that question, we need to understand the scale of what might be missed. The figures from Ireland are striking, although they are less straightforward than a headline might suggest. In 2023, the Economic and Social Research Institute used the Problem Gambling Severity Index in an online survey of 2,850 adults. The weighted estimate placed 3.3% in the problem-gambling category, with a 95% confidence interval of 2.5-4.0%, while a further 7.1% showed moderate evidence of problems (1). The former corresponds to approximately 130,000 adults, but it does not mean that 130,000 people have received a clinical diagnosis. Moreover, the estimate was more than ten times an earlier Irish figure of 0.3%, obtained through face-to-face interviews. It would be tempting to interpret this as a dramatic increase in harm. However, the two surveys cannot sustain that conclusion. Differences in recruitment, anonymity and survey mode may help explain the discrepancy, and the ESRI authors themselves acknowledge limitations to generalisability. In this respect, the uncertainty is almost as revealing as the estimate. How we ask about a sensitive behaviour can influence what we are able to measure. The consultation is not a population survey, of course, but both depend upon a person feeling able to give an honest answer.

The consequences of gambling also extend beyond the obvious financial loss. In the same ESRI research, greater gambling-problem severity was associated with poorer mental-health scores,

while people reporting problem gambling within their family also described poorer mental health (1). Crucially, these are associations rather than evidence of a single direction of causation. Distress may precede gambling-related harm, develop because of it, or become entangled with it over time. The clinical significance lies in that overlap. Indeed, a study of 1,058 patients attending eleven English general practices found gambling problems alongside presentations involving depression, risky alcohol use and drug use (2). The sample cannot tell us how common such problems are in Irish general practice. It does, however, help explain why gambling may be encountered without being named. A patient may describe anxiety rather than money lost, or relationship difficulties rather than the behaviour that has contributed to them. Equally, the person attending may be a partner or relative carrying the consequences of somebody else's gambling. In general practice, mood, sleep, substance use, finances and family relationships rarely arrive as neatly separated problems. They accumulate in the same history. What is interesting is the possibility that gambling may sometimes be the missing connection between concerns we have already taken seriously.

This is why waiting for a patient to volunteer the word 'gambling' can be an inadequate approach. NICE's 2025 guideline, although developed for England and not binding on Irish practice, offers a useful distinction. Clinicians are advised to consider asking about gambling when discussing smoking, alcohol or other substances, even without obvious risk factors, and to ask directly in settings such as mental-health difficulties, self-harm, substance dependence, financial concerns, homelessness and safeguarding issues (3). Medicines associated with impaired impulse control, including dopamine agonists and aripiprazole, are relevant too. Nevertheless, these circumstances must guide enquiry rather than substitute for diagnosis. Depression and debt do not establish gambling disorder, any more than an individual's age or sex should determine whether they deserve to be asked. Instead, a cluster of clinical concerns can make an additional question reasonable. The way it is asked matters just as much. Someone sitting beside a partner may not feel free to discuss financial secrecy or coercion, while a hurried or judgemental question may close a conversation before it begins. When asked privately and without accusation, however, an enquiry about gambling need not be fundamentally different from other sensitive questions in a history. We already recognise the clinical importance of context; this is another place to apply it.

Of course, recognising the need to ask does not tell us which question to use. NICE favours direct, ordinary language, including whether a person gambles and whether they have concerns about their own or someone else's gambling (3). That seems more inviting than asking someone to identify themselves as having a 'gambling problem' before a conversation has even begun. Brief screening instruments may be useful, but their results need careful interpretation. The three-item NODS-CLiP, which examines loss of control, concealment and preoccupation, performed well against the longer NODS in its original American development

samples (4). Yet its performance changed when tested among 1,058 attendees in English primary care. It identified all ten participants above that study's higher-severity PGSI threshold, but only nine of forty-five people with low-to-moderate scores (5). Furthermore, the Brief Biosocial Gambling Screen reported sensitivity of 0.96 and specificity of 0.99 for DSM-IV pathological gambling in its original United States household data (6). Impressive figures, certainly, but neither result establishes how well these instruments would capture earlier harm in an Irish GP surgery. Nor does either make a positive screen a diagnosis. The distinction matters: the purpose of the first question is to allow a concern to emerge; only then can its severity and consequences be properly assessed.

At first glance, the logical response seems to be to ask everybody. There is a serious argument for that approach. People without recognisable risk factors may still experience harm, and relying upon clinical intuition alone may reinforce the very stereotypes that keep some patients overlooked. A standardised question could offer permission to disclose without making anybody feel singled out. That argument can be compelling. Yet it leaves one essential question unanswered: does finding more positive screens reliably lead to better outcomes? A systematic review found evidence that gambling screening in health, care and support settings could be feasible and acceptable, but substantial uncertainty remained around effectiveness and cost-effectiveness (7). Moreover, a positive result may require further assessment and support, while a negative result can be falsely reassuring when a brief tool fails to identify less severe difficulties. Those consequences matter in a consultation already balancing competing clinical needs. The tempting bet is to treat a completed questionnaire as though it has resolved uncertainty merely because it produces a score. While expecting the evidence to favour universal formal screening; instead, it makes one more cautious. Importantly, this does not return us to the original silence. It suggests a more proportionate approach, one in which direct enquiry becomes normal when clinically relevant, without turning every encounter into a formal screening programme.

The argument becomes more demanding once someone answers yes. Identifying a problem is only useful if we are prepared to respond to it. In Ireland, the route from disclosure to care is neither absent nor entirely straightforward. The HSE's 2023 dual-diagnosis model placed gambling and gaming disorders outside the initial phase of its specialist programme, with later inclusion dependent on resources (8). However, a planning document from 2023 should not be mistaken for a complete account of services in 2026. Dedicated provision has been developing, and voluntary and community services remain important. The Gambling Regulatory Authority of Ireland lists HSE addiction services, free specialist counselling through Extern Problem Gambling, Gamblers Anonymous, the GamblingCare national helpline and other treatment options (9). Thus, there are genuine places to begin, although access and the type of support available may differ. A directory, after all, is not necessarily a coordinated pathway.

Consider what is being asked of someone who has finally disclosed a deeply private problem, only to receive a number and have to explain everything again to a stranger. This is where the GP's responsibility becomes more than simply recognising a risk. The question must lead to a response that takes the patient's circumstances seriously, rather than merely adding another item to the medical record.

What follows need not be an elaborate intervention, but it does require clinical care. The first step is to understand what the gambling is doing to the person's life: whether there is loss of control, debt, concealment, relationship strain, associated substance use, medication-related impulsivity or concern for somebody else's safety. Importantly, NICE recommends direct assessment of suicidal thoughts and intent in people experiencing gambling-related harm (3), while Ireland's 2026-2035 suicide and self-harm strategy recognises gambling as a factor requiring coordinated attention (10). Immediate danger therefore requires urgent assessment and the appropriate crisis or emergency response. Otherwise, the conversation can move towards the person's wishes, the support available, financial advice where needed, and follow-up in general practice. Family involvement may be helpful, but only where appropriate, safe and agreed. Nor should treatment be presented as a guaranteed solution. A meta-analysis of twenty-nine randomised trials found benefits from cognitive-behavioural techniques immediately after treatment, although a statistically significant advantage was not demonstrated at follow-up and heterogeneity complicated interpretation (11). Such uncertainty does not make care futile. Rather, it reminds us that recovery may be difficult, uneven and rarely settled by a single consultation. Continuity can matter precisely because disclosure is only a beginning.

In this respect, the GP's contribution is not to become a specialist gambling therapist. It is to recognise a possible source of harm, understand its significance and help the patient find a way forward. The distinction protects against two errors. On one hand, a positive NODS-CLiP result should not be treated as proof of gambling disorder. On the other, a negative result does not establish that gambling is harmless to the patient or their family. Clinical judgement must take account of the wider circumstances. Is this occasional gambling without discernible consequences, an emerging financial problem, a possible disorder, a medication-associated impulse-control difficulty, or distress experienced by someone affected by another person's behaviour? These are not interchangeable situations, and they may change over time. General practice has the advantage of returning to a concern without demanding that everything be resolved at once. At the same time, that relationship depends on respecting boundaries. A patient may decline to discuss gambling, and sensitive information about finances, relationships and third parties must be handled with appropriate confidentiality. Enquiry is not surveillance, nor should it become a test of whether somebody is being truthful. Its value lies in

creating a space where a relevant difficulty can be acknowledged without reducing the person to it.

Nevertheless, even the most attentive consultation cannot address the entire environment in which gambling-related harm develops. Ireland's Gambling Regulation Act 2024 established a regulatory framework covering licensing, consumer protection and a Social Impact Fund, with licensing implementation progressing in 2026 (12,13). The fund is intended to support activities including treatment, education, research and public awareness (14). These developments recognise an important reality: gambling-related harm cannot be explained solely through individual decisions or shortcomings in self-control. The availability, promotion and design of gambling products involve responsibilities far beyond the consulting room. Better questioning in general practice must therefore complement, rather than replace, regulation and specialist services. Each has a different role. Public policy can address features of the commercial environment; specialist providers can deliver focused treatment; and the GP may be the person who first connects sleeplessness, financial pressure and family distress in a way that makes sense to the patient. What matters is not claiming that one part of the system can do everything, but recognising where its contribution begins and where collaboration becomes necessary. The consultation is only one point of contact, yet for an individual who has said very little about their difficulties, it may be an important one.

How, then, might this be translated into everyday Irish practice? It should not begin by adding a compulsory gambling question to every ten-minute appointment. Instead, a more realistic approach would combine basic education about gambling-related harm with clear prompts to consider it when discussing mental health, substance use, financial difficulties or relevant medications. Practices would also benefit from keeping current information on local and national supports, so that disclosure is followed by something more useful than uncertainty about where to turn. The enquiry itself should remain straightforward, private and non-judgemental. If a concern emerges, the record should reflect the harm described and the plan agreed, rather than impose a diagnostic label prematurely. Importantly, this approach should be evaluated. Practices could examine not merely whether the question was asked, but whether appropriate follow-up occurred and whether patients could access help. Existing evidence does not establish that such an approach would reduce gambling-related harm at a population level (7). Nevertheless, its rationale is clinically coherent: recognise relevant circumstances, ask plainly, assess carefully and remain involved where needed. The ambition is not to create a new screening industry within general practice, but to improve the quality of a history we already take.

Ultimately, general practice has always depended on more than the information that appears readily in a consultation. It depends upon asking questions that allow unfamiliar or uncomfortable parts of a person's life to become clinically understandable. Ireland now has enough evidence to recognise gambling-related harm as a genuine health concern, even if prevalence estimates remain uncertain and identification tools imperfect. Similarly, support exists, although navigating it may still be difficult. None of these limitations justifies treating gambling as somebody else's subject. Of course, there may be no gambling-related harm behind the disturbed sleep, low mood or financial anxiety with which this essay began. A patient may simply answer no, and that answer deserves respect. But where the clinical context makes gambling relevant, choosing not to ask should no longer seem the more neutral option. The better bet is to accept uncertainty, ask with care and take responsibility for what the answer reveals. This is not a call to turn every consultation into a screening exercise. It is a reminder that the history is only as complete as the possibilities we allow ourselves to consider. Sometimes the first useful intervention is not an answer at all, but making it possible for an answer to be given.

Declaration of Originality

I hereby declare that this essay is my own original work, contains no plagiarism, and has been produced without the use of artificial intelligence (AI).

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The Man Behind the Medical Record: Listening, Understanding and the Limits of Knowing in General Practice

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Introduction

“Upbeat and pleasant.” These were the words used to describe a man I encountered during my general practice placement in Sligo, Ireland. He was in his seventies, living with chronic obstructive pulmonary disease (COPD), bronchiectasis, previous lung and prostate cancer, and a history of depression. He attended his appointments, engaged with his care and, by conventional clinical measures, appeared to be coping well.

My clinical supervisor encouraged me to spend time speaking with him, explaining that he would offer a valuable insight into contemporary rural Irish general practice. I could not have anticipated how profoundly the conversation would change my understanding of the patient sitting before me.

Over almost two hours, he disclosed something that fundamentally altered my perception of him: his deepest fear was being alone, and he believed that, if left alone, he would end his life.

I had arrived at the consultation as a 4th year medical student, accustomed to thinking about illness through diagnoses, investigations and management plans. I left with a different understanding of what it means to care for a patient. Beneath a reassuring presentation lay a lifetime of trauma, bereavement, shame and fear, alongside a determination to remain alive for his family. His medical record contained the names of his diseases; it could not convey the meaning of living with them.

This encounter led me to consider a question central to general practice: how well can we know a patient if we attend primarily to what is clinically visible? Drawing on Rita Charon’s work on narrative medicine (1), this essay explores the importance of listening to patients’ stories, recognising psychological distress in people with multimorbidity, and the responsibility of general practitioners to translate understanding into action. It also examines my own emotional response to witnessing suffering and the kind of doctor I hope to become.

Beyond The Problem List

The patient, whom I will call Mr. A, had a medical history that could readily occupy an entire consultation. His COPD and bronchiectasis required ongoing management, his cancer history necessitated surveillance, and his depression, polypharmacy and other chronic conditions complicated his care. As I learned about his health, I began to understand that his experience of illness could not be separated from the experiences that had shaped his life.

He described growing up as the eldest of eight children. His father had been protective, but his relationship with his mother was profoundly painful. He recalled emotional abuse and an incident in childhood when she struck him on the head with a high-heeled shoe, causing a brain haemorrhage. He associated his longstanding fear of being alone with these early experiences. Silence, he explained, could become unbearable.

He later found enduring companionship in his wife, to whom he had been married for fifty years. Their life together had also been marked by devastating losses. They had lost a twin during pregnancy, and one of their sons died at fourteen following severe bullying. Mr. A described the circumstances surrounding his son's death, the distressing reactions of others and the subsequent estrangement of family members. He had attempted suicide in the aftermath and had never received formal counselling specifically addressing his bereavement.

His account did not present grief as an event that had ended with a funeral. Rather, the loss remained woven into his experience of family, identity and safety, influencing how he understood his own survival and relationships decades later.

Charon argues that narrative medicine involves recognising, interpreting and responding to the stories through which patients communicate illness (1). Such stories reveal dimensions of suffering that biomedical descriptions alone cannot capture. Mr. A's history illustrated this distinction. His COPD was a respiratory diagnosis, but its meaning extended beyond breathlessness: it limited his activities, affected his independence and intensified his fear of being alone. His prostate surgery had treated a physical disease, yet he described feeling that he had lost his manhood. The significance of treatment could not be understood solely through its clinical outcome.

Engel's biopsychosocial model offers a complementary framework, recognising the interaction of biological, psychological and social factors in health and illness (2). Mr. A's physical conditions affected his functioning; trauma and bereavement shaped his psychological experience; and his relationships, faith and responsibilities influenced how he coped.

Nevertheless, even the biopsychosocial model can become another checklist if clinicians identify psychological and social factors without understanding what they mean to the individual. Mr. A did not simply have a history of bereavement, depression and family difficulties. He had a particular story in which loss, fear, belonging and survival were inseparable. Listening allowed these connections to emerge.

The Privilege and Responsibility of Vulnerability

What struck me most was not only what Mr. A disclosed, but that he disclosed it at all. He told me he would be at risk of suicide if left alone. He had stopped swimming because he feared he might deliberately remain in the water and drown. These were not details I had understood from his clinical history or from the description of his usual presentation.

I felt privileged that he trusted me with such intimate information. I also felt unprepared for the responsibility that accompanied it.

Charon's work helped me understand why listening is more than a passive act (1). Clinical attention requires us to remain receptive to a patient's words, silences and particular ways of expressing distress. We must try to understand the experience being communicated without immediately reducing it to a diagnosis or a problem to be solved.

Mr. A's disclosures emerged gradually, as the conversation allowed him to move beyond the information ordinarily exchanged in a clinical appointment. I began to appreciate that a patient's willingness to speak about suffering cannot be assumed. It depends, in part, on whether the patient feels there is space to do so.

It would be simplistic, however, to conclude that two hours of listening are always necessary, or that every general practice consultation should become an extended exploration of a patient's life. General practitioners work within real constraints: appointments are short, demand is substantial, and multiple clinical problems compete for attention. The challenge is to recognise when a patient's circumstances require us to look beyond the presenting complaint.

A question about sleep, hesitation when discussing family, or an apparently reassuring answer about mood may warrant further exploration. Curiosity and attentive listening can help clinicians recognise these openings.

The contrast between Mr. A's outward presentation and private distress was particularly unsettling. He could be pleasant, sociable and engaged while experiencing profound emotional pain. This does not mean his general practitioner had failed him; one conversation cannot establish everything that was or was not known within his ongoing care. Rather, it highlights a limitation of clinical impressions: outward demeanour is not a reliable substitute for asking about a patient's internal experience.

For general practice, where relationships may extend across years, this raises an important question. How can continuity of care help us recognise the person behind the presentation, while guarding against the assumption that familiarity means complete understanding? Continuity can support trust and a broader understanding of patients' needs, but it does not guarantee that every aspect of their experience will become visible (3).

Listening Must Lead to Action

There was an uncomfortable tension between the trust Mr A placed in me and my position as a medical student. I could listen, ask questions and seek to understand, but I was not independently responsible for his care. His disclosure of possible suicide risk made this distinction especially important.

Reflecting on the encounter, I recognise that empathy alone would not have been sufficient. A disclosure of suicidal intent or a credible possibility of self-harm requires a proportionate, timely clinical response. In practice, I would need to communicate the concern promptly to my supervising general practitioner, clarify the immediate level of risk through appropriate assessment, and ensure that necessary safety measures and follow-up were arranged. If there were immediate danger, urgent assessment and intervention would take precedence over completing a reflective conversation.

It would be inappropriate to infer a patient's level of suicide risk solely from a history of depression, a reassuring presentation or a single statement. Equally, a patient denying suicidal thoughts during a formal consultation should not automatically lead clinicians to dismiss other concerning disclosures. Risk assessment requires direct questioning, clinical judgement and an understanding of the patient's circumstances, support and access to means of self-harm.

Mr. A's grandchildren were central to his account of survival. He spoke of them with warmth and looked forward to his youngest grandchild receiving First Holy Communion. His Christian faith also offered continuity and hope, including the belief that he would one day be reunited with his deceased son. His family, faith and future expectations appeared to provide meaning during periods of distress.

These protective factors mattered, but they could not be treated as guarantees of safety. A person can have meaningful relationships, spiritual beliefs and reasons to live while remaining vulnerable to suicidal thoughts. The task is to understand these sources of strength alongside the risks, rather than allowing one to obscure the other.

This has important implications for general practice. Psychological distress should be explored without judgement, and protective factors should inform not replace an individualised safety plan. Where appropriate, care may involve renewed mental health support, attention to bereavement, collaboration with relevant services and clear arrangements for seeking help during a crisis. Understanding a patient's story must lead to appropriate action, rather than remaining a meaningful conversation without clinical follow-through.

The Particular Value of General Practice

Mr. A's circumstances demonstrated the complexity of caring for someone with multimorbidity. He was living with significant respiratory disease, a history of cancer, depression and numerous prescribed medications. His wife had experienced a stroke, and he had assumed a caring role despite having substantial health needs of his own.

He worried about the effect of his own deterioration on his wife, while also carrying responsibility for her care. His wish to protect her from witnessing him near death revealed another dimension of their relationship: he wanted to spare her further suffering, even as he struggled with his own.

General practice must respond to such complexity without losing sight of the individual. Medication reviews, chronic disease monitoring, cancer surveillance and respiratory management remain essential. They are not made less important by psychological distress; their value is enhanced when they form part of a coherent understanding of the patient's priorities and circumstances. This broad, person-centred approach is central to family medicine (4).

The HSE's structured chronic disease management arrangements provide a framework for reviewing conditions such as COPD, supporting self-management and coordinating care. Eligible patients with COPD can receive two reviews over twelve months, each involving their GP and practice nurse (5). Yet structured reviews cannot, by themselves, guarantee that emotional needs will be identified. A completed questionnaire or reassuring response may need to be followed by a conversation exploring what the answer means in the patient's life.

Mr. A also made me reconsider the boundaries of clinical responsibility. His wife's stroke affected his wellbeing, but she was not a patient of the practice. His caring role could therefore be overlooked if attention remained confined to his own diagnoses. Asking about caring responsibilities, strain and available support could help identify unmet needs and opportunities for referral or signposting.

Similarly, his feelings about prostate surgery reminded me that treatment outcomes cannot be measured exclusively through disease control or survival. Changes in sexuality, bodily confidence and identity may affect relationships and psychological wellbeing. Sensitive discussion of these concerns should be part of holistic care, rather than an optional addition once the medical problem has been resolved.

There is also a danger in turning every aspect of a patient's life into a clinical intervention. Not every grief requires referral, and not every source of meaning needs to be medicalised. Respectful care involves asking what matters to the patient, recognising when professional support may help, and allowing room for experiences that cannot be fixed by medicine.

For Mr. A, faith, family and social connection were not peripheral details. They were resources through which he understood his life and imagined his future. A patient-centred approach would seek to support these resources where appropriate, rather than imposing a predetermined understanding of wellbeing.

Bearing Witness Without Becoming Overwhelmed

As Mr. A described the death of his son and the abuse, he had experienced, I found myself struggling to hold back tears. His story was difficult to hear, particularly because events that had occurred many years earlier continued to carry such emotional weight.

I had assumed that becoming a good doctor would involve learning to remain composed in the face of suffering. This encounter complicated that assumption. My emotional response did not necessarily indicate a lack of professionalism; it reflected the impact of being entrusted with another person's pain. At the same time, I recognised that feeling deeply affected did not automatically mean I knew how best to help.

Charon's concept of bearing witness provided a useful way of thinking about this tension (1). To listen to suffering is to acknowledge that it has occurred and that it matters. A clinician need not claim to fully understand another person's experience to take it seriously. Nor should the patient's story become an occasion for the clinician to centre their own emotions.

I also began to understand that bearing witness has limits. I cannot carry every patient's pain indefinitely, nor can I promise to resolve every injustice, loss or fear that emerges in consultation. Attempting to do so could undermine my judgement and capacity to care for others. Conversely, emotional detachment risks reducing people to clinical problems and protecting me at the expense of meaningful engagement.

The challenge is to develop a sustainable form of empathy: remaining open to suffering while recognising professional responsibilities and limitations. Reflective writing, supervision, peer discussion and appropriate support can help clinicians examine their emotional responses rather than suppressing them or allowing them to dictate clinical decisions. For medical students in particular, recognising the limits of one's competence is not a failure. It is a reason to seek guidance, communicate concerns and remain accountable to the patient.

What I Will Carry Into Practice

Mr. A did not describe himself solely through the suffering he had experienced. He spoke of perseverance, his marriage, his grandchildren, his faith and his love of being among people. His story contained pain, but it also contained agency and hope.

That distinction matters. If I remember Mr. A only as a man with a history of trauma and suicidal thoughts, I will have missed much of what he wanted me to understand. If I remember only his resilience, I may overlook the seriousness of his distress. Good care requires space for both.

The encounter has changed how I think about the medical record. The record remains indispensable: it preserves diagnoses, treatments, investigations and decisions that allow care to be delivered safely. But it cannot fully represent the meaning of illness to the person living

with it. A diagnosis may describe COPD; it cannot explain what breathlessness means to someone who fears being alone. A history of prostate surgery may describe a treatment; it cannot capture the shame or altered sense of identity a patient associate with it.

Narrative medicine does not ask clinicians to choose between scientific medicine and human understanding. It asks them to bring these forms of knowledge together. The story informs clinical judgement, while clinical knowledge helps the clinician respond safely and effectively.

In my future practice, I hope to ask questions that allow patients to express concerns they may not initially volunteer. I want to be attentive to discrepancies between a reassuring presentation and the difficulties a patient describes, without assuming that I can see beyond every outward appearance. I will aim to explore psychological distress directly when indicated, recognise the significance of family and social circumstances, and communicate concerns to colleagues when a patient's safety may be at risk.

I also want to become more comfortable acknowledging uncertainty. I cannot know precisely what Mr. A experienced throughout his life, and I should not mistake his willingness to tell me his story for complete understanding. Listening is an invitation to understand, not proof that understanding has been achieved.

Conclusion

During my placement in Sligo, I met a man whose medical record described serious illness but could not convey the full extent of his suffering. In a conversation that extended well beyond the usual boundaries of a consultation, he entrusted me with experiences that challenged my assumptions about resilience, mental health and clinical care.

The encounter revealed both the power and the limitations of listening. It showed me how a patient's story can expose needs hidden behind a reassuring presentation and reminded me that hearing a disclosure creates responsibilities extending beyond empathy. For general practice, the task is to combine attentive listening with sound clinical judgement, continuity, communication and appropriate action.

Charon's work helped me understand that the patient's narrative is not an optional supplement to medical knowledge. It is one way clinicians come to understand what illness means, what matters to the person experiencing it, and how care might respond to their needs.

I cannot know whether I changed Mr. A's life by listening to him. I can, however, recognise that he changed my understanding of medicine. I entered the conversation thinking about a patient with multiple chronic conditions. I left thinking about the responsibility of meeting a person whose life cannot be contained by a list of diagnoses.

Perhaps the most important lesson I learned was that a patient can appear to be coping while carrying distress that remains largely unseen. The task of general practice is not simply to

identify disease, but to remain curious about the person living with it. Sometimes, the first step towards better care is not a new investigation or prescription. It is making enough room for the patient to tell us what we have not yet understood.

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Confidentiality statement:

To protect patient confidentiality, the patient's name and selected identifying details and contextual elements have been modified. The central experiences and learning points have been retained to the best of my ability, without intending to misrepresent the clinical encounter.

Declaration:

The above piece is original and contains no plagiarism or use of AI

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Not Just Recorded: Can Shared Records Maintain Continuity of Care?

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In lectures, continuity of care was introduced as one of the defining principles of general practice: the idea that a patient's care should remain connected over time, and informed by their history and previous care. Yet when we began to explore the structure of the Irish healthcare system, this principle appeared less straightforward. A patient may move between their GP, an emergency department, hospital consultants and community services, while the information needed to care for them does not always move as seamlessly. I found this contradiction striking. The patient remains the one constant throughout their journey, yet their medical history may become fragmented between different parts of the health service. As Ireland begins a transformation of its digital health infrastructure, this raises a more fundamental question, **if a patient's information can finally follow them through the health service, is that enough to preserve continuity of care?**

Before considering what shared records might change, it is important to ask why continuity matters in the first place. Continuity of care is not simply the convenience of seeing the same doctor repeatedly. Haggerty et al. (2003) described three interconnected dimensions: 1) *informational continuity*, where relevant information from previous encounters is available to inform current care; 2) *management continuity*, where care remains coherent across different providers; and 3) *relational continuity*, where an ongoing therapeutic relationship develops between a patient and their clinician. These distinctions are particularly relevant to general practice, where patients may be cared for over many years rather than during a single episode of illness.

Evidence increasingly suggests that continuity has measurable consequences. A recent study involving more than 100,000 adults in Dutch general practice found that longer registration with a GP practice was associated with lower odds of urgent hospital admission and lower hospital costs (Te Winkel et al., 2026). Continuity is especially important for patients with complex needs. Among individuals with dementia approaching the end of life in England, greater continuity with GPs was associated with fewer multiple hospital admissions, while a subsequent study found that those experiencing perfect continuity had, on average, lower total healthcare costs during their final year of life (Leniz et al., 2022, Leniz et al., 2026).

Although these observational studies cannot establish that continuity itself causes better outcomes, they suggest that knowing a patient over time may have value extending beyond patient satisfaction.

This may become progressively relevant to Ireland as its population ages. As of April 2026, approximately 891,100 people living in Ireland were aged 65 years or older, representing 16.1% of the population. According to the Central Statistics Office's M2 projection, this figure could rise to approximately 1.23 million by 2037 (CSO, 2026). An ageing population is likely to bring greater levels of multimorbidity, polypharmacy and interaction with multiple parts of the healthcare system. For such patients, continuity of information and management becomes increasingly important.

Consider a patient who attends their GP prior to presenting at an emergency department and then being admitted to the hospital. During that admission, investigations may be performed, diagnoses reconsidered and medications started, stopped or adjusted. On returning to their GP, safe ongoing care depends on knowing what occurred between the two GP visits. *Why was a medication discontinued? Were abnormal results identified? Who is responsible for arranging follow-up?* Traditionally, the GP may not immediately have had access to all the relevant information held elsewhere in the health service.

The patient themselves may attempt to fill these gaps, but this places an unreasonable responsibility on them. A patient may remember that "one of my tablets was stopped" without knowing its name, the reason it was discontinued, or whether it should later be restarted. Similarly, information that appears clinically important to a doctor may not appear important to the patient recalling an unfamiliar and stressful hospital admission. The problem is therefore not that patients provide an inadequate history, but that they can become responsible for carrying clinical information between otherwise disconnected parts of their healthcare.

The Irish College of General Practitioners has described continuity of care "as a defining strength of general practice" while noting that health records outside general practice have historically been "fragmented and/or siloed". It highlights that gaps in information flow can leave GPs coordinating care with incomplete or outdated information, while patients may have to repeat their histories or undergo duplicated investigations (GPs, 2025). The college has consequently identified "Connected Care", including shared electronic records as a priority for the future of Irish general practice.

Ireland has started to address this fragmentation. The HSE Shared Care Record is now available across all six health regions, providing authorised healthcare staff with read-only access to selected patient information drawn from different sources. This includes primary care reimbursed scheme medication information, GP-requested laboratory and radiology reports, chronic disease management assessments, referrals, discharge summaries and appointment information (HSE). Its importance lies in its potential to strengthen informational continuity. Rather than relevant parts of patient's history remaining separated according to where their care was delivered, clinicians can begin to see a more coherent picture of that patient at the point of care.

The Shared Care Record should be distinguished from the HSE's planned One Health Record, Ireland's larger national electronic health record programme. The One Health Record is intended to replace multiple paper records and separate IT systems across HSE health and social care settings with longitudinal electronic record in which healthcare staff can record, update and retrieve information. The HSE currently plans to begin its first regional deployment in Dublin and the North East in 2029, with national availability targeted for 2032 (HSE). For general practice, its value will depend particularly on how effectively information can be shared between these national system and existing GP records.

These developments could substantially strengthen informational continuity. A clinician who knows that a medication was altered during a recent admission, can view relevant discharge information and has access to recent investigation is better placed to make an informed decision than one working with only part of the clinical picture. The Shared Care Record may also reduce time spent searching for records and unnecessary repetition of investigations. For an Irish health system seeking to provide more integrated care between hospitals and the community, this represents an important advancement.

Digital transformation may also change the patient's relationship with their own medical information. The HSE envisages that patients will eventually be able to access their own records online through the One Health Record programme (HSE). Patient access could move the individual from being a passive recipient of information towards becoming a more active participant in their care. Rather than relying entirely on communication between healthcare professionals, patients may increasingly be able to see the information on which decisions about their health is based.

The significance of this became more tangible to me during a recent conversation with someone who had undergone blood testing and was awaiting the results. She had been told

that the specialist would send the results to her GP and that the GP would then contact her. Three weeks had passed without contact. Eventually, she asked whether the results could be sent directly to her instead.

It was an ordinary experience, rather than a failure of care, yet it made me reconsider where patients sit within the process of their own medical information. The person whose blood had been tested was also the person waiting for information to travel successfully between two healthcare professionals before she could receive it. There have been entirely reasonable explanations for the delay, but the experience raised an important question: *if information concerns the patient's own health, should the patient themselves have a greater role in accessing it?*

Research suggests that patient access to electronic record can have benefits. A recent systematic review of 19 studies involving more than 200,000 participants found that online access to clinical notes was associated with high patient satisfaction, increased engagement and stronger patient-provider trust. Some studies also reported improvements in medication adherence and identification of inaccuracies within records (Yoshimura et al., 2026).

However, access to information does not necessarily ensure understanding. Patients vary in their levels of health literacy, and medical terminology may therefore need to be communicated in clear and accessible language to support comprehension and enable patients to better understand and engage with their own care. Lausen et al. (2018) found that GPs used a range of communication strategies to support patients with health literacy difficulties and that recurring encounters helped GPs recognise individual communication needs and adapt their explanation accordingly.

This creates a challenge for patient-accessible records. Medical notes have traditionally been written primarily to facilitate precise communication between healthcare professionals. A pathology result, radiology report or clinical note may make immediate sense to the clinician reading it while appearing confusing to a patient encountering the same terminology without further explanation. A future digital health system must therefore make information accessible not simply technologically, but also in a form that patients can understand.

The answer is not to make individual GPs responsible for translating every clinical document into lay language, especially in a system in which administrative workload is already considerable. The Irish College of GPs has specifically warned that advances in eHealth must not result in an inappropriate transfer of work from secondary care into general practice (GPs,

2025). Instead, patient-facing systems should be designed so that clear explanations, appropriate context and accessible language are incorporated wherever possible, while recognising that some results will still require discussion with a healthcare professional.

Yet this leads to another important question.

If every doctor can see a patient's medical record, do they truly know the patient?

A shared record may show a diagnosis of diabetes, an HbA1c result, a hospital admission, a medication list and previous investigations. These are invaluable pieces of information. But a record may not reveal as easily that patients habitually minimises their symptoms, that they are reluctant to take a specific medication because of a previous experience, or that a routine concern carries particular meaning because of a past event.

Here, the distinction between informational and relational continuity becomes important. A shared record can allow a GP to know more about their patient. A continuing therapeutic relationship allows the GP to know the person represented by that record.

When I was first introduced to continuity of care in lectures, I primarily understood it as care remaining connected over time. Understanding Ireland's changing health system has made me realise that continuity is more complex. Shared electronic health records can help that information follow the patient, reducing gaps between services and supporting safer clinical decisions.

However, the challenge for Irish general practice is not simply to create a system in which information follows the patient. It is to ensure that as informational continuity improves, the relational continuity in general practice is not mistaken for something that technology itself can reproduce. Shared records may help maintain continuity of care, but only as a tool through which relationships and clinical understanding are supported rather than replaced.

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Miles from an Answer: The Geography of Uncertainty in Irish General Practice

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Consider two patients, each arriving at their general practitioner with the same troubling complaint: persistent fatigue, intermittent abdominal pain and an unintentional loss of weight. One lives in Dublin, within easy reach of several major hospitals. The other lives in a remote village along Ireland's western coastline, where attending a hospital appointment may mean arranging transport, taking a day away from work and travelling considerable distances. Neither patient has an obvious diagnosis. Both require careful assessment, appropriate investigation and a clinician willing to revisit the possibilities as their symptoms evolve. Yet the journey towards an answer may unfold very differently. For one, an appointment might be an inconvenience measured in hours. For the other, it could demand an entire day's planning, financial sacrifice and the assistance of family. Their symptoms are identical, but the circumstances surrounding their care are not. In a healthcare system committed to treating patients according to clinical need, how much should the distance from home to hospital matter?

Medical education teaches us to recognise the significance of age, medical history, presenting symptoms and clinical findings when formulating a differential diagnosis. Geography rarely appears alongside these familiar considerations, yet it can influence what happens after the consultation ends. The availability of investigations, accessibility of specialist services and practical feasibility of repeated appointments may all shape a patient's diagnostic journey. For general practitioners, whose clinical decisions must account for both medical evidence and individual circumstances, these inequalities introduce an additional dimension of uncertainty. Some uncertainty is inherent to medicine: symptoms evolve, investigations have limitations and diagnoses are not always immediately apparent. Other uncertainty may be prolonged by obstacles that have little to do with the underlying disease. Distinguishing between the two is essential, because while medicine cannot always promise an answer, the opportunity to seek one should not depend on where a patient happens to live.

The distance between a patient and healthcare is not merely metaphorical. In July 2026, Ireland's Central Statistics Office published a national analysis revealing striking geographical differences in proximity to health services. In cities, the average road distance to a general practitioner was 0.8 kilometres, compared with 6.1 kilometres in highly rural or remote areas. The disparity widened considerably for hospital services: the corresponding distances to an HSE general hospital were 3.7 and 35.9 kilometres, respectively [1]. These figures describe

physical proximity rather than waiting times or the availability of appointments, yet they expose an important inequality in the practical circumstances of seeking care. In some communities, even the first step towards medical assessment requires considerable planning. For patients whose symptoms demand repeated investigations, specialist consultations or ongoing monitoring, each additional journey may represent another disruption to employment, family responsibilities or daily life. Geography does not determine the quality of clinical judgement, nor does distance alone establish whether a diagnosis will be delayed. Nevertheless, it can shape the circumstances in which patients seek care and clinicians attempt to provide it.

Yet the geography of healthcare cannot be reduced to a division between rural disadvantage and urban convenience. A patient living within walking distance of a hospital may still face substantial barriers to accessing its services, while someone in a remote community may benefit from an established relationship with a local GP. Financial circumstances, transport availability, disability and the distribution of healthcare resources complicate any simple relationship between distance and access. Research by the Economic and Social Research Institute, using data from 6,326 participants in the Healthy Ireland survey, identified a significant association between neighbourhood deprivation and GP utilisation, demonstrating the importance of considering geographical and socioeconomic circumstances together [2]. The CSO's 2026 findings offer another revealing perspective: among people living in highly rural or remote areas without access to a car, one in four lived more than 8.3 kilometres from their nearest GP [1]. For such patients, the challenge is not simply the distance recorded on a map, but the means available to cross it. The distinction matters because healthcare accessibility is not measured solely by the presence of a service. It must also account for whether patients can realistically reach and use that service when they need it.

The journey from symptom to diagnosis is rarely a straight line. In general practice, a complaint that initially appears nonspecific may become more concerning as symptoms persist, new findings emerge or treatment fails to produce the expected improvement. Clinical reasoning is therefore an evolving process, requiring GPs to balance the possibility of serious disease against the harms of unnecessary investigation. A referral may represent an important step towards diagnostic clarification, but it does not necessarily bring uncertainty to an end. At the close of September 2026, 692,524 patients in Ireland were awaiting their first public hospital outpatient consultation, according to the National Treatment Purchase Fund [3]. This figure does not distinguish patients awaiting diagnostic clarification from those referred for other reasons, nor does it establish geographical differences in waiting times. Nevertheless, it illustrates the scale of the interval between primary and specialist care. During that interval, symptoms may change, concerns may intensify and patients may return repeatedly to the clinician who initiated their referral. Where accessing further assessment also involves substantial travel or logistical difficulty, the journey towards diagnosis can become more complicated still.

The clinical significance of waiting, however, depends upon what lies behind the symptoms. For someone with suspected malignancy, timely investigation may be essential to identifying disease at a treatable stage. A systematic review and meta-analysis published in the *BMJ* found that a four-week delay in cancer treatment was associated with increased mortality across several major cancer types and treatment modalities [4]. Although these findings concern treatment delays rather than geographical barriers or delays before diagnosis, they illustrate why time cannot always be regarded as clinically neutral. Elsewhere, progressive neurological symptoms may require reassessment as new deficits emerge, while chronic inflammatory conditions may cause accumulating pain, functional impairment and disruption to everyday life before diagnostic clarification is achieved. These presentations differ in urgency, prognosis and the potential consequences of delay. They also demonstrate why equitable access cannot mean treating every patient identically. It must involve ensuring that clinical need, rather than the practical difficulty of reaching care, guides the urgency of assessment. Geography should inform how healthcare is delivered, not become an unacknowledged determinant of how long a patient must wait.

Yet the burden of diagnostic uncertainty cannot be understood entirely through waiting-list figures or clinical outcomes. Between the first consultation and an eventual explanation lies a period in which patients must continue living with symptoms whose significance remains unresolved. Some may wonder whether their condition is deteriorating; others may struggle to explain repeated absences from work, changing physical limitations or the anxiety of awaiting investigations. For patients facing substantial journeys, each appointment may demand arrangements that extend far beyond the consultation itself. The financial cost of travel, dependence on others and uncertainty surrounding future appointments can become additional pressures, particularly when symptoms make ordinary activities difficult. These experiences should not be assumed to affect every patient equally, but they reveal why the diagnostic journey deserves attention beyond its eventual destination. A diagnosis may provide a name for an illness, guide treatment and offer some measure of reassurance. Until then, the GP may be asked to manage not only the patient's symptoms, but also the uncertainty that surrounds them. And sometimes, even after investigations have been completed, that uncertainty remains.

Not every diagnostic journey ends with an answer. Some patients undergo appropriate investigations, attend specialist consultations and return to general practice with persistent symptoms but no definitive explanation. Persistent physical symptoms are familiar to primary care, encompassing presentations such as chronic pain, fatigue, dizziness and gastrointestinal disturbances that may not be fully explained by identifiable disease. Their complexity challenges a central assumption of modern medicine: that sufficiently thorough investigation will eventually reveal the cause of suffering. Yet an inconclusive test is not evidence that a symptom is imagined, nor does the absence of an established diagnosis diminish its impact on a patient's life. Equally, diagnostic uncertainty must not become an invitation to investigate

indefinitely. Repeated testing can expose patients to incidental findings, unnecessary interventions and further anxiety without necessarily improving their care. The difficulty lies in recognising when investigation has been proportionate, when emerging clinical features warrant reassessment and when management should focus on improving function and quality of life despite continuing uncertainty [5]. Geography introduces another complication into this already delicate judgement. For patients facing substantial barriers to specialist assessment, it becomes particularly important to distinguish symptoms that remain unexplained after appropriate evaluation from those for which reasonable investigation has not yet been accessible. The distinction is clinically significant: uncertainty arising from the limitations of medical knowledge is not necessarily equivalent to uncertainty sustained by limited opportunities to obtain that knowledge.

For patients, however, the absence of an explanation can be experienced as something more personal than a diagnostic limitation. A normal investigation may reassure the clinician that a particular disease is less likely, while leaving the patient no closer to understanding why they continue to feel unwell. The consultation can become strained when medical reassurance does not correspond with the patient's lived experience, particularly if repeated encounters leave them feeling that their symptoms have been minimised. Research examining patients with persistent physical symptoms has highlighted the importance of validation, collaborative explanations and continuity in establishing effective therapeutic relationships [6]. Here, general practice offers something that cannot be provided by investigation alone: the opportunity to know a patient beyond an isolated episode of illness. A GP familiar with an individual's previous health, circumstances and changing functional abilities may recognise subtle developments while helping them navigate uncertainty without repeatedly beginning their story anew. This does not mean that continuity guarantees diagnostic accuracy, or that empathy can substitute for necessary investigations. Rather, it recognises that listening, reassessment and thoughtful explanation remain forms of clinical care even when a diagnosis is elusive. For someone who has travelled considerable distances seeking an answer, being heard should not become another obstacle to overcome. Medicine may not always be able to explain suffering, but it should never require certainty before taking that suffering seriously.

Yet uncertainty does not always demand immediate action. In a profession increasingly equipped with sophisticated investigations and expanding therapeutic possibilities, the decision to refrain from intervention can appear counterintuitive. Nevertheless, clinical restraint is not the absence of clinical judgement, but often its careful application. In general practice, where symptoms frequently present before their significance becomes apparent, watchful waiting can allow self-limiting conditions to resolve while avoiding investigations and treatments whose potential harms outweigh their benefits. The principles of quaternary prevention similarly encourage clinicians to protect patients from unnecessary medical intervention, recognising that overdiagnosis, incidental findings and inappropriate treatment can themselves become sources of harm [7]. Such restraint, however, is neither passive nor

indefinite. It requires a considered assessment of risk, clear communication, appropriate safety-netting and an agreed plan for reassessment should symptoms persist or evolve. Its justification rests not simply on what the clinician chooses against doing, but on the continuing care provided while observing. Indeed, knowing when not to investigate may require as much clinical discernment as recognising when urgent intervention is necessary. The difficulty emerges when the freedom to exercise that judgement is constrained by circumstances beyond the consultation room.

There is a profound ethical difference between choosing to wait and having no practical alternative. A GP who recommends observation following an appropriate assessment exercises clinical restraint; a GP who recognises the need for further investigation but cannot secure timely access to it confronts a different dilemma. Both situations may result in a patient returning home without an immediate answer, yet the reasoning, responsibilities and potential consequences are not interchangeable. In geographically underserved communities, where travel difficulties or limited local services may complicate access to further assessment, this distinction deserves particular attention. The principles of beneficence and non-maleficence require clinicians to balance the benefits and harms of intervention, but justice demands consideration of whether patients have equitable opportunities to receive clinically indicated care [8]. A decision shaped by limited resources should not be mistaken for one justified solely by clinical evidence. Nor should responsibility for structural shortcomings be placed entirely upon individual practitioners, who may have little control over referral capacity or service distribution. The ethical challenge is therefore not to eliminate waiting, an impossible and potentially undesirable ambition, but to distinguish necessary observation from avoidable delay. Perhaps the most troubling form of geographical inequality is not simply that some patients must travel farther for care, but that the boundaries of what is clinically possible may differ according to where they live. When waiting becomes unavoidable, the GP must still ensure that it does not become abandonment.

When a diagnosis remains uncertain, the general practitioner often becomes the one constant in an otherwise fragmented journey. Patients may encounter different specialists, undergo investigations across multiple facilities and wait between appointments with little indication of when an answer might emerge. Yet throughout these transitions, many return to the same consultation room, where their history is already known and their concerns need not be explained from the beginning. This continuity represents more than familiarity. Longitudinal care allows clinicians to recognise changes that might be less apparent during isolated encounters, reconsider earlier assumptions and interpret new symptoms within the broader context of a patient's life. A systematic review by Pereira Gray and colleagues found that greater continuity of care with doctors was associated with lower mortality, although the observational nature of much of the evidence limits causal interpretation [9]. For patients living far from specialist services, a trusted local GP may therefore provide an especially valuable source of clinical oversight and reassurance. However, continuity should not be romanticised

as a substitute for investigations or specialist expertise. The therapeutic relationship is most meaningful when familiarity strengthens clinical vigilance rather than encouraging complacency. A patient whose symptoms persist despite previous reassurance deserves renewed consideration, just as one whose condition deteriorates requires timely escalation. The value of general practice lies not in possessing every answer, but in maintaining responsibility for the questions that remain unresolved.

That responsibility, however, has practical and ethical limits. A GP may recognise the need for urgent assessment, communicate concerns clearly in a referral and repeatedly advocate for a patient whose condition is worsening, yet remain unable to determine when specialist care becomes available. In such circumstances, patient advocacy must be accompanied by realistic mechanisms for maintaining safety: explicit advice about concerning symptoms, accessible follow-up, reassessment of clinical urgency and communication between primary and secondary care. The geographical circumstances of individual patients should also inform how these arrangements are made. A recommendation to return promptly if symptoms deteriorate carries different practical implications for someone with reliable transport and nearby services than for someone whose journey requires considerable planning or assistance. Equitable care therefore demands more than offering identical instructions; it requires considering whether patients can realistically act upon them. Nevertheless, expecting GPs to compensate indefinitely for inaccessible services risks transferring responsibility for systemic failures onto clinicians already working within finite resources. Their role as advocates is essential, but advocacy cannot create appointments, shorten every waiting list or remove the financial burden of travel. General practice can help patients navigate the distance between symptoms and answers, but it cannot be expected to close that distance alone.

Closing these distances requires more than bringing healthcare facilities closer to patients. It demands a reconsideration of how diagnostic pathways accommodate the circumstances of those who must navigate them. Expanding access to community-based investigations, strengthening communication between general practice and specialist services, and developing clearer mechanisms for reassessing patients whose symptoms evolve while awaiting appointments could reduce some of the uncertainty surrounding referral. Where clinically appropriate, remote consultations may lessen the burden of repeated travel, although their value depends upon reliable connectivity, digital accessibility and recognition of when physical examination remains essential. Transport support and better coordination of appointments could further ease the practical demands placed upon patients living far from specialist facilities. Such measures are consistent with the broader ambition of Sláintecare to deliver more integrated, accessible healthcare closer to home [10]. Yet service planning must look beyond the distribution of buildings and professionals to consider the journeys patients actually undertake. Distance, transport availability, socioeconomic disadvantage and the capacity to attend repeated appointments should inform efforts to improve access. Crucially, these reforms should not encourage indiscriminate investigation or undermine appropriate

clinical restraint. Their purpose is to ensure that decisions about when to investigate, observe or refer are guided principally by clinical need rather than by the limitations of geography.

Return, then, to the two patients whose journeys began with the same troubling symptoms. Their eventual diagnoses remain unknown, as do the precise challenges each might encounter. One may receive an explanation quickly; the other may continue searching. Their circumstances do not allow us to predict their outcomes, but they invite us to question whether both have been afforded a fair opportunity to seek answers. Medicine will always involve uncertainty. No clinician can promise that every symptom will be explained, every investigation will be conclusive or every illness will be recognised immediately. What a healthcare system can strive to provide, however, is equitable access to the expertise, investigations and continuing care through which uncertainty is responsibly managed. For the Irish GP, this means recognising geography not merely as the place a patient comes from, but as part of the circumstances in which illness is experienced and care becomes possible. Ultimately, the distance between a patient and a diagnosis should be determined by the complexity of their illness, not the location of their home. **Distance should be measured in miles, not in the time it takes for a patient to be heard, investigated or believed.**

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Why Bother Diagnose?

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Why Early Recognition of Endometriosis Matters in General Practice

When the news about *Endotest* came in I almost gasped: called the "Game Changing" test, it allows General Practitioners (GPs) to screen for endometriosis using a saliva-based test, with a reported sensitivity of 96% to 97.3% and specificity from 94.1% to 100% in the trials [17]. Although diagnostic accuracy alone does not establish its suitability for routine screening in general practice, the numbers were promising. For women who have spent years seeking answers, the prospect of a less invasive route to diagnosis felt like a reason to celebrate.

Indeed, I was sceptical when discussing it with my GP mentor. I was not sure if my excitement for a new test would be shared. Nonetheless, I still expected more enthusiasm. It was a non-invasive test and had created more hope for similar or enhanced tests in the future. At the very least, it had drawn more attention towards Endometriosis. However, my excitement was immediately shut down: 'why does it matter to diagnose endometriosis? We as GPs can only manage the symptoms, the rest is up to the gynecologist. all we can do is refer?'. I was not ready for that statement.

'Have I been naïve?' was my first thought, followed by a vision of my previous coworker. I used to work as an administrative assistant at a hospital prior to becoming a medical student. We shared a cubicle wall, walked during our lunch breaks and had our coffee runs to the cafeteria together. It was during the cubicle talks that I learned about her condition. Once a month, whenever she couldn't make it to work, I knew she was having excruciating pain at home. I sat at my desk, logging her sick day into the system, wondering why I got to be here and not forced to use my sick days for something that was bound to happen every month, while another young woman had to safeguard those days for a debilitating condition that took years to diagnose.

This biological injustice remained in my headspace years later, and that is why I was overjoyed with the news regarding Endotest. While it may not be immediately actionable, an official diagnosis for endometriosis does matter. It matters for women who cannot regularly take time off work, for those whose department heads are not as understanding as ours was, for women who have to disappear from social circles monthly, cancel plans they had had looked forward to, and live with uncertainty about their pain. An uncertainty that could require only one word to be justified: Endometriosis.

While there are limitations to the scope of clinical investigations in general practice, I believe there is room to shift the perspective of endometriosis diagnosis from limitations to realizing how crucial GPs can be in hastening the diagnosis of endometriosis. Their impact can be compared in two possible scenarios: the correspondence from GP to Gynecologist vaguely alludes to endometriosis, asking for further investigation. In contrast, another referral letter that clearly states there is a positive screening test, indicating that the patient is highly likely to have Endometriosis, and a definitive diagnosis through laparoscopic surgery is all that remains to bring it all together. Changing the heading of the referral letter can make a substantial difference in what the patient goes through and more importantly: for how long. It may also help gynaecologists use their time and resources more efficiently. Not to mention, when it is all over, it is the GP who will continue the endometriosis journey with the patient – not the gynecologists.

While our knowledge is growing about this condition, a brief introduction on current status quo is as follows. Endometriosis is a chronic, inflammatory disease and it is characterized by the presence of endometrial-like tissue outside the uterus. It can present with debilitating pelvic pain, dysmenorrhea, dyspareunia, dyschezia, and infertility, which can severely affect daily activities and mental health [1]. Its symptoms overlap with several other systems such as gastrointestinal, urinary and other pelvic conditions, which further complicates recognition [1]. And while our perception of endometriosis could be a monthly pattern, symptoms may extend beyond a cyclical pattern and make diagnosis even more challenging [1]. Things are more complicated by the fact that scans can still be normal, meaning normal imaging does not exclude endometriosis [4].

Meanwhile, this painful condition can take more than just a GP visit to gain closure: several studies show that it can take approximately up to 7-10 years from onset of symptoms to a confirmed diagnosis [6] [12] [16]. One example of how many life events that timeline can encompass is my colleague who spent another year in our department, got accepted into a Master's program abroad, moved to another country with her partner, and has been finalizing her degree since. This was 3 years of her life and there could be more to come while her diagnosis could still be pending.

Another issue I came across as I spoke with more GPs was less awareness about the prevalence of the disease. This can be understandable since our data is limited in Ireland: based on Irish Department of Health, the exact number of women who have endometriosis is unknown but recent research estimates that it affects as many as one in seven women [7]. While there is more research to be done, the very first step could be recognizing that it is not as rare as it is thought and inviting the GPs to have this differential in mind when encountering the umbrella condition of chronic pelvic pain. This recognition that not all period pain is normal can be the first step towards expediting the diagnostic process and shorten the time when patients receive appropriate treatment.

Still, it remains a valid query: why is it important for GPs to start the process of diagnosing Endometriosis if ultimately, the golden standard diagnosis lies in the hands of the Gynecologist? This may be the consequence of a bureaucracy that exists in a healthcare model, in which GPs are the first line of contact with patients, which makes them be considered the “gatekeepers” of more specialized services [12] such as gynecology. However, it simultaneously increases the impact of GPs in reducing wait times to specialist care. This could be in fact be of benefit to patients, since GPs could be significantly more aware of how debilitating a chronic condition can be for their patients on a daily basis.

Nevertheless, research shows that an Endometriosis diagnosis remains a lengthy process, and unfortunately, GPs are one factor: one study in Netherlands involved 139 patients diagnosed at a Dutch secondary-care hospital with a specialist endometriosis team. They found that the median time interval from the onset of symptoms to diagnosis was 89 months or 7.4 years [16]. It also reported a median GP-related delay of 35 months, compared with 7 months attributed to patients and 5 months to gynaecologists [16]. These reported intervals do not account for the full 89-month total, but they highlight the importance of the primary-care stage in the diagnostic journey [16].

One counterargument to hastening the diagnosis may be that GPs’ hands are tied by protocols when it comes to diagnostic procedures, which must be followed in a stepwise manner. That is almost always true. However, this cannot remain the case for Endometriosis: Ireland's National Framework for the Management of Endometriosis recommends a *presumed*-diagnosis approach allowing treatment and referral based on symptoms [7]. This framework recognises that the diagnostic process should not depend on definitive confirmation before care begins [7]. This is consistent with NICE guidelines, which recommend ultrasound *alongside* the initial treatment and referral when symptoms persist or affect daily activities [14]. With the core of these recommendations being symptom recognition and prompt action, once again, the role of general practice is highlighted. This requires GPs to have endometriosis as a likely differential, rather than a rare condition. It also encourages GPs to investigate alternative causes and ensure that proper reassessment is done when symptoms are persisting, rather than continuing with symptomatic management.

Despite this urge to ask GPs to be cognisant of Endometriosis as a likely possibility, it is not to say GPs are not doing their due diligence in referring to specialist services. Although not exclusive to endometriosis, HSE’s *Ambulatory Gynaecology Model of Care* reported that outpatient gynaecology referrals increased by 109.2%, from 51,645 in 2020 to 108,039 in 2024 [10]. Although these figures include referrals for all gynaecological conditions, the increase may reflect growing demand for, or access to, gynaecological assessment. This can be further strengthened by GPs initiating treatment when suspicion is raised.

Meanwhile, GPs should be aware that their task is not completed by referring to gynecology, as patients might still wait a long time to see a gynecologist. The National Women and Infants Health Programme provided numbers for outpatients waiting list for specialist endometriosis services [11]. The wait time in 5 centres[1] and number of patients on waiting list were reported as below:

Time	Number of patients on the wait list
0 - 3 months	315
3 - 6 months	268
6 - 9 months	159
9 - 12 months	132
+12 months	171

At the end of December 2025, the five established specialist services collectively recorded 1,045 patients on their outpatient waiting lists, with 44.2% waiting more than six months and 16.4% waiting 12 months or longer [11]. However, the 1,045 number represents patients already on the outpatient waiting lists for established specialist endometriosis services. It does not include those who are still waiting for a diagnosis, meaning the overall number of women waiting for endometriosis care would be higher [11]. This brings the discussion back to the role of GPs, asking them to be mindful that treatment should not be postponed, and a recognition of condition based on a "presumed diagnosis" [7] can be significantly impactful before patients are seen by gynecology.

Patient Experience

I wondered if my colleague was one of many women who had to miss work, then what is the overall experience in the larger population in Ireland? An Irish study interviewed 20 women about their experiences [12]. Women reported they had to miss work because of symptoms, take extended sick leaves, reducing workload, and changing to self-employment partly to accommodate healthcare access [12]. Some even felt their career progression was stalled due to the impact of disease on their jobs [12]. While this is not a quantitative representation of financial loss of the system, it echoes the loss of productivity in the workplace. Another commonly reported feeling of being 'let down' by healthcare services in Ireland and feeling dismissed by healthcare professionals became a barrier for many participants to seek further treatment [12].

Another noted theme was that there are not sufficient healthcare services nor support and education [12]. One patient reported that: "*They thought originally that I might have had*

Crohn's, so I've had 3 colonoscopies and 2 endoscopies. I've had the barium swallow test, a pillcam test, MRIs, ultrasounds. I've just had so many tests done" [12]. This account illustrates several challenges: lack of education, lack of diagnostic tools and the importance of diagnosing sooner to save time and expenses, both for the patient and the healthcare system. The financial burden on patient might even extend beyond the established care as some patients reported they had to travel abroad for their treatment [12]. This could lead to further challenges in continuity of care, further complications and a disruption in the management.

Amongst reported experiences, there was a familiar one: dismissive attitudes and normalising severe pain [12]. One of the reasons my colleague hesitated to pursue her diagnosis further was being dismissed by her physician. For some women, this could be the end of the road: acceptance of one's fate and no longer attempting to seek care. For a future Master's student trying to move her life abroad while completing a vigorous degree, the uncertainty of how to manage an unnamed condition may be one too many things to bring to a new country.

Similarly, I spoke with a patient during my placement who explained she had to miss at least 1 week of school during her periods and was told this is normal. Her menarche was at 11 years old, and she was explaining that as an 11-year-old who has just gotten her periods, a 'normal' period pain has not yet been defined. And the same teenager being dismissed at an early age by her GP may normalize her pain for a long time or hinder her from seeing her GP about her issue.

This ties into the fact that the burden of endometriosis could exist from adolescence. In a retrospective case-control study, women aged 15–19 years, those with endometriosis were more likely than controls to have visited a primary care physician (76.9% vs. 46.2%) and/or a gynaecologist (57.7% vs. 14.4%) [8]. These differences also existed among women aged 20–24 years, although to a smaller degree [8]. Use of oral contraceptives and pain medications were also significantly higher among women with endometriosis in both age groups and antidepressant use was higher among those aged 20–24 years [8]. It was also found that the median direct medical costs per person were twice those of controls in the youngest age groups [8].

These findings show Endometriosis reaches to a younger age group, who could greatly benefit from their GPs being vigilant about their symptoms at a vulnerable age. This is to invite GPs to be more mindful of how impactful their conversations could be with younger patients, particularly about gynecological conditions.

Fertility, Another Issue

Amongst the expressed lived experiences, there was one that was deeply touching: "*it's extremely upsetting because like the odds of me ever having a child now are like really extremely low* [12]. It echoes the despair in one's imagined future and brings fertility to the forefront of reasons for GPs to think ahead.

A prolonged diagnostic process may seem less immediately consequential during adolescence, but its implications can extend into adulthood. When a young woman later presents to her GP with fertility concerns, earlier recognition of suspected endometriosis may help her make informed decisions about investigation, treatment and reproductive planning. Although earlier diagnosis cannot guarantee better fertility outcomes, it may help patients navigate their options sooner.

Therefore, it is important to ask about patients' family planning goals and consider the implications of suspected endometriosis. While not all people with endometriosis will experience infertility, it is estimated that about 30–50 % of women with endometriosis have infertility, and about 20–50 % of infertility patients have endometriosis [9]. According to Irish Department of Health, it is estimated that 47% of women who experience fertility issues have endometriosis [7]. This is further complicated by the fact that in many cases, endometriosis may only be suspected or diagnosed when a woman undergoes fertility investigations [7].

As a result, it occurred to me why are the success chances if a woman with Endometriosis and fertility issues sought Assisted Reproductive Treatment (ART). A retrospective Australian cohort study explored whether the timing of an endometriosis diagnosis was associated with women's fertility treatment journeys [13]. Among 459 women with endometriosis who had undergone assisted reproductive treatment, around one-third were diagnosed only after their first treatment cycle [13]. Women with endometriosis diagnosed after first ART were more likely to use Intrauterine insemination (IUI) and do more cycles [13]. There also less likely to report a birth, compared to women without endometriosis, despite no significant difference in starting age [13]. These findings suggest that delayed recognition may be associated with a longer and more burdensome fertility journey [13]. While this was an observational study and cannot establish that delayed diagnosis caused these outcomes, it Nevertheless signifies the burden of fertility journey on both the patient and the system.

What to look for?

Hopefully by shifting the perspective from limitations to possibilities, a promising question can be: what can GPs do to shorten the diagnostic delay? One first step is to maintain a high index of suspicion.

First, GPs can recognise the pattern of symptoms by actively asking about symptoms:

- dysmenorrhoea that interferes with normal activities
- chronic pelvic pain
- deep pain during sex
- cyclical bowel symptoms, particularly painful defecation
- cyclical urinary symptoms
- infertility

- fatigue
- bowel symptoms that fluctuate with menstruation [4] [14]

Second, they could aim to measure the functional impact of the disease by asking if the patient is missing work/school, has the pain stopped them from socializing [12] [14] or other measures that are relevant to the patient. A careful menstrual history, including bleeding pattern and severity, can also help characterise the presentation and inform further assessment.

Third, if the clinical picture is convincing, the GP can make a presumed diagnosis and manage based on suspected endometriosis [7] [14]. This includes asking about patient's fertility plans. Depending on the patient and whether she is trying to conceive, this can include appropriate analgesia or progesterone therapy [7] [14].

To conclude, the aim is not to criticise GPs for the limitations they face in diagnosing endometriosis, but to encourage a higher index of suspicion when the clinical picture is consistent with the condition. Earlier recognition can help reduce diagnostic delays, support informed reproductive planning, and ensure that patients receive appropriate management while navigating referrals and waiting lists. Ultimately, these steps can make a meaningful difference to patients' quality of life.

In the end, a general practitioner may not be the one to confirm the diagnosis, but they may be the one who makes the years before it count.

Statement: This essay was a result of my personal reflections and research on Endometriosis. It is an original piece of work, with no plagiarism or use of AI.

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