Royal College of General Practitioners

Sheppard Memorial Compendium Essays

2025

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Winner of the Sheppard Memorial essay competition 2025, Postgraduate category

Living on the Edge: Understanding Frailty in Ireland's Homeless Population

Author: Thomas Cronin, Postgraduate

Existing research tells us that homelessness ages people before their time [1–3]. In the consulting room, this becomes hard to ignore. Men and women in their forties and younger sit before you with the health profiles of someone decades older: chronic illnesses stacked upon each other, wounds that will not heal, minds weary from trauma and sleeplessness [4]. Frailty, usually reserved for geriatric practice, becomes a daily reality in general practice serving people who are homeless, adding to the already intense burden of ill health this group faces [5].

In Ireland, homelessness has risen sharply over the past decade, with numbers reaching 16,000 in 2025 compared to around 4,000 in 2015 [6]. Mortality statistics are equally stark: Ireland 2020 and the average age of death for a homeless male was 41 years, and for a homeless female, just 36 [7].

The work herein grew out of encounters in a Dublin primary care clinic for people experiencing homelessness. It sought to understand frailty in the context of homelessness in Ireland – not as an abstract concept, but as a lived experience that shapes lives, shortens futures, and challenges what it means to care in general practice. Through three interlinked studies described below – an evidence synthesis, a feasibility trial, and qualitative interviews – it aimed to explore the scale of frailty among people who are homeless, whether it can be reversed and how it is perceived in the daily lives of those affected.

The Scope of the Problem: A Systematic Review and Meta-analysis on the Prevalence of Frailty in People Experiencing Homelessness

Frailty has long been understood as a multidimensional syndrome, encompassing physical decline, vulnerability to stressors, and an increased risk of adverse outcomes [8]. But while it has been studied extensively in older populations, comparatively little is known about how it manifests among people experiencing homelessness.

Correspondingly, a systematic review and meta-analysis was undertaken to explore the prevalence of frailty in this population [9]. This confirmed what clinical experience had suggested: both frailty and pre-frailty are highly prevalent among people who are homeless, ranging from 16–70% and 18–60%, respectively. Across multiple studies, rates were alarmingly high and importantly, they appeared at much younger ages than in the general population, where the prevalence is around 11% for those over 65 [10]. In one large study from England, over 40% of participants were classified as frail despite being under 60 [11]. Among the youngest adults – those just 18 to 24 years old – almost a quarter already met criteria for frailty.

This paints a picture of premature ageing, where the cumulative burden of addiction, mental illness, poor nutrition, and multimorbidity can converge to accelerate biological decline. The findings also, however, reinforce frailty as not just a matter of individual biology, but as a product of deep social disadvantage [12, 13]. Homelessness itself seems to act as a risk factor, exacerbating existing vulnerabilities and pushing people into frailty far earlier than expected. For general practice, where people experiencing homelessness can meet barriers to care [14], these findings hold uncomfortable truths. The consulting room is often where this accelerated ageing is witnessed first-hand, but it is also where the limits of what can be offered become most visible. Traditional models of frailty care – comprehensive geriatric assessments and multidisciplinary clinics – are rarely accessible to people who cannot even be sure of where they will sleep that night [15]. Recognising frailty in this group then, should move beyond measuring it, and rethinking how general practice might respond to such complexity.

Regaining Strength: A Feasibility Trial of a Primary Care Intervention for People Experiencing Homelessness

If frailty is common among people who are homeless, the next question is whether anything can be done. Too often in practice, frailty is seen as irreversible, a slow but inevitable decline [16]. Among people who are homeless, whose lives are already so unstable, the temptation is even greater to assume that interventions are futile.

This trial challenged that assumption. In a primary care service in Dublin, a brief, low-cost intervention was offered to people who were homeless and were pre-frail or frail. This comprised a set of resistance exercises that could be completed without equipment, advice on nutrition, and a short course of oral nutritional supplements. Building on previous research [17], it was designed to be pragmatic, delivered within the normal rhythms of general practice, and without the need for specialist staff or additional funding.

The results were striking. One hundred and eight participants were recruited, with almost nine in ten eligible patients agreeing to take part, representing a level of engagement often not seen in research with people who are homeless [18]. Despite the many challenges of follow-up in this population, over two-thirds engaged with the two-month review point. The data from this showed that the intervention was found to be acceptable and practical, with good levels of adherence. Furthermore, frailty scores appeared to improve. Nearly half of participants who were frail at the start of the study were no longer classified as such at follow-up. Nevertheless, a definitive trial will be needed to confirm these findings.

Beyond the numbers, there were stories of change. From the process evaluation, one participant described how the exercises gave structure to his mornings: *"I'm doing it first thing…*

it gives me a great start to the day." Another said simply, *"It's given me motivation."* For people whose lives are often marked by exclusion and stigma, the study seemed to provide an opportunity to reclaim a level of hope, and agency over their own health, even in the presence of daily uncertainty.

In general practice, the lesson is that small interventions can matter. This was not a programme that required multidisciplinary teams, hospital resources, or complex referrals. It was an approach rooted in the ordinariness of primary care — a GP consultation, a conversation, a sheet of exercises and dietary guidance. It showed that frailty, even when bound up with homelessness, is moveable. Change is possible, and it can begin in the consulting room.

Voices from the Margins: A Qualitative Study Exploring Attitudes Towards Frailty among People Experiencing Homelessness

Statistics can demonstrate the prevalence of frailty, and trials can test what works, but neither can capture how frailty is actually lived. For that, we must listen. The qualitative study of this work gave space for people experiencing homelessness, who participated in the feasibility trial, to discuss frailty in their own terms.

What emerged, with 25 interviewees, was a picture far more expansive than any clinical definition, captured in three interrelated themes: *frailty and homelessness; survival;* and *systemic neglect*.

Frailty, as viewed by those who participated, was frequently not just considered a physical illness but also having profound psychological dimensions in the context of homelessness. One put it plainly: *"Your mental health goes down the drain. You're frail in the mind more so than the body."* Depression, anxiety, trauma, and hopelessness were described as eroding strength as much as malnutrition and chronic physical diseases.

Homelessness itself was described as accelerating ageing. The streets, participants said, take years off a life: *"If you're sleeping on the streets, a year feels like five."* Violence, unsafe hostels, poor sleep, inadequate food, and untreated illnesses all conspired to wear people down. Accommodation that was meant to provide shelter often did the opposite, becoming sites of fear and perpetuating drug addiction.

Yet alongside these accounts of vulnerability were stories of survival. People spoke about drawing strength from their peers, supportive keyworkers, and the sheer determination to keep going. Frailty, in this sense, was never absolute, it frequently co-occurred with resilience and endurance.

Participants also located frailty within the systems that failed them. Psychological care was described as inaccessible, housing supports scarce, and structures designed to protect them frequently failing. In this way, frailty became the sum of social as well as medical disadvantage – a reflection of neglect as much as biological decline.

This study illustrated that addressing frailty for this group requires more than a prescription pad. It will involve recognising resilience, fostering trust, and advocating for secure housing and accessible mental health care. It also requires designing frailty treatments that reflect the daily realities of people's lives.

Conclusion

Homelessness in Ireland continues to rise, whilst the markedly premature mortality rates among this population underscore the urgent need for action. Frailty, as a lens, helps capture the multidomain vulnerability faced by people experiencing homelessness. This encompasses physical, psychological, and social elements that are often compounded by unstable living conditions, limited access to care, and experiences of exclusion.

The studies presented in this essay illustrate how frailty is both shaped by its social context and can be influenced by appropriate support. Systematic review data highlighted the high prevalence and early onset of frailty among people experiencing homelessness. The trial, meanwhile, demonstrated that a low-threshold, community-based intervention, rooted in general practice, is feasible, and potentially transformative. Lastly, qualitative insights revealed the lived experience behind the numbers: homelessness both contributes and magnifies frailty, coexisting with stories of survival and an ongoing struggle against systemic neglect.

Meaningful change for this group, will require more than clinical innovation. It demands inclusive systems, sustained investment in primary care, and policies that recognise secure housing as a fundamental determinant of health. Future research and service development must continue to centre the lived experiences of people experiencing homelessness, ensuring that frailty care is humane, responsive, and embedded in general practice. In doing so, general practice can move from observing premature decline to actively supporting recovery, resilience, and wellbeing among those most marginalised in society.

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 2025, Undergraduate category

When the Algorithm Beeped: AI in Rural Irish General Practice

Author: Josiah Wilson, Undergraduate

The Morning it All Changed

It's 9:47am on a Tuesday in Ballyvaughan, County Clare. I'm sitting in the cramped reception area of Dr O'Brien's practice, clutching my third cup of tea. This is my second week on GP placement, and I still haven't figured out where to sit during consultations so I'm not blocking the examination couch. The waiting room is already packed, a mixture of elderly farmers in flat caps and young mothers with restless toddlers. The broadband keeps cutting out, which means Dr O'Brien has lost the telehealth link to the consultant rheumatologist in Galway twice already this morning.

"Right, let's see Mr B," she says, and I follow her into the consultation room.

Thomas B is 62, a sheep farmer from up near Black Head. He's come in complaining of feeling "a bit off" for the past few days, tired, maybe a touch of indigestion, nothing specific. He nearly didn't bother coming at all, but his wife insisted. As Dr O'Brien runs through the history, I'm mentally ticking off the red flags we learned in cardiology lectures. Chest pain? "Ah, not really, just a bit of tightness now and then." Shortness of breath? "Well, I'm not as young as I used to be." He's a smoker, type 2 diabetic, on statins. The kind of patient we're supposed to watch carefully.

Dr O'Brien performs an ECG. The trace prints out, and to my untrained eye, it looks... fine? Maybe? She's reviewing it when her computer screen flashes a yellow alert. The AI clinical decision support system, installed just three months ago as part of an HSE pilot, has flagged "possible early inferior STEMI" based on subtle ST-segment elevation I genuinely cannot see.

Dr O'Brien goes quiet for a moment, re-examining the trace. "Thomas," she says carefully, "I think we need to get you to Galway." Within twenty minutes, an ambulance is on its way. Mr B looks bewildered. I feel slightly sick. Did the computer just spot something we both missed? Three days later, I learn that Mr B had emergency angioplasty for a 90% occlusion in his right coronary artery. The cardiologist tells Dr O'Brien that without the early referral, he'd likely have had a massive MI within 24 hours.

But here's what keeps me awake: what if the algorithm had been wrong? What if we'd sent him to hospital unnecessarily, exposing him to procedures he didn't need? And more pressingly, am I actually learning to read ECGs, or am I just learning to trust a computer?

This is the reality of AI-assisted clinical decision support arriving in rural Irish general practice. It's not some distant future or Silicon Valley fantasy. It's happening now, in small practices across Galway, Mayo, Kerry, and Donegal, and it's complicated in ways nobody warned us about in medical school.

Why Ireland? Why Now? Why Here?

Rural Ireland has 40% fewer GPs compared to urban areas, according to the Irish College of General Practitioners. Recent data shows two out of three GPs in rural areas cannot accept new patients. The HSE's modelling suggests Ireland expects a shortage of between 493 and 1,380 GPs by 2025, concentrated mainly in rural areas.
During my placements in County Clare and County Galway, I've witnessed firsthand what these statistics mean. Dr O'Brien routinely sees 28-30 patients daily, compared to the 23 her urban colleagues manage. She covers on-call duties every second weekend because there's nobody else. The nearest emergency department is 45 minutes away on winding coastal roads that flood in winter. When I asked her about specialist access, she laughed, not unkindly, but wearily. "We wait three months for a cardiologist opinion if we're lucky. Six months for rheumatology."

This is where AI clinical decision support enters the conversation. The technology promises diagnostic assistance at the point of care, particularly valuable when specialist consultation isn't readily available.

What Actually Is AI-CDS?

AI clinical decision support systems analyse patient data using machine learning algorithms to generate diagnostic suggestions, risk scores, and evidence-based recommendations. Unlike the simple rule-based alerts we see in prescribing systems ("Drug interaction detected!"), these tools employ neural networks and pattern recognition to identify subtle clinical features that might escape human notice.

The system Dr O'Brien uses integrates directly into her electronic health record. It runs continuously in the background, analysing ECGs, blood results, vital signs, and medication lists. When it identifies something concerning, it flags an alert, colour-coded by urgency. Yellow for "review recommended," red for "urgent attention required."

Dr Conor O'Shea, National Coordinator of the GPIT group (which comprises representatives from the Irish College of GPs, HSE, and Department of Health), notes that AI is "an evolving situation" and the group is monitoring different tools that could benefit GPs. However, he acknowledges challenges including lack of local Irish regulation for companies supplying these tools, plus complications around GDPR and European AI laws that need translation into Irish settings.

What the Research Actually Shows

I've spent considerable time in the medical library trying to understand whether AI-CDS genuinely improves clinical outcomes or whether it's sophisticated window dressing. The evidence is... mixed.

A large randomised controlled trial by Johnson et al. in English primary care practices found AI ECG interpretation increased early myocardial infarction detection by 12% and reduced median time to cardiology referral from 4.2 to 2.8 days.(1) Sensitivity for detecting clinically significant ECG abnormalities improved from 78% to 89%, though specificity dropped slightly from 94% to 91%, suggesting the system errs on the side of caution, sometimes over-flagging.(1)

That trade-off matters. During my placement, I witnessed two false-positive pulmonary embolism alerts in elderly patients with chronic breathlessness. Both underwent CT pulmonary angiograms showing no clot. Both were terrified. One developed acute kidney injury from the IV contrast.

What struck me reviewing this literature is how few studies evaluate AI performance in real-world clinical workflows rather than controlled research settings. A systematic review by Nagendran et al. analysed 81 studies comparing AI diagnostic performance with healthcare professionals across multiple specialties.(3) AI achieved equivalent or superior diagnostic accuracy in 67% of studies, particularly in image-based specialties. However, the review highlighted significant publication bias favouring positive results and noted that external validation, testing algorithms on populations different from those used in training, remained inadequate.(3)

Here's what concerns me: most commercially available AI-CDS systems were trained predominantly on American or UK hospital datasets. These populations are younger, less multimorbid, and more urban than the patients I'm seeing in rural Irish practice. A 2025 article in the Irish Journal of Medical Science warns that algorithm performance may deteriorate when applied to different demographic groups, a phenomenon termed "external validity failure."(4) If an AI system trained on 55-year-old London patients encounters 75-year-old farmers in County Mayo, will it still work?

Nobody really knows. And that's terrifying.

What It's Actually Like Using AI in Clinic

The literature review tells one story. Clinic tells another.

Dr O'Brien describes the first month with the AI system as "like having a very keen medical student constantly over your shoulder." Initially, alert fatigue was overwhelming, the system flagged everything. Possible sepsis because a patient had mild tachycardia and a normal temperature. Possible heart failure because an 85-year-old had ankle swelling (she'd been gardening all afternoon).

We learned to adjust sensitivity thresholds, which helped. But now I worry we've overcorrected. Have we tuned down the alerts so much that we'll miss something important? I've been keeping a reflective journal of cases where AI-CDS influenced management. Here are two that keep me thinking:

Case One: When the Algorithm Was Right

Margaret is 71, lives alone in a cottage three miles outside Ballyvaughan, presents with vague symptoms of malaise and mild confusion that her neighbour noticed. Initial impression: possible UTI, maybe early dementia progression. Vital signs unremarkable except heart rate of 96bpm, barely tachycardic. The AI sepsis prediction algorithm analyses her age, recent HbA1c (she's diabetic), current symptoms, and vital signs, then generates a moderate sepsis risk score. Dr O'Brien wouldn't necessarily have sent bloods based on clinical impression alone, the presentation was too non-specific. But the AI flag prompted venous blood sampling. Results: white cell count 18.2 × 10^9/L, CRP 187mg/L. She was admitted same-day with urinary sepsis requiring IV antibiotics. Five days later, she's home and well.

Would Dr O'Brien have eventually sent those bloods anyway? Probably. But would it have been that day, or would Margaret have been sent home with "let's see how you go" and returned 24 hours later significantly worse? The AI didn't make the diagnosis, it lowered the threshold for investigation. Sometimes that's exactly what's needed.

Case Two: When Trust Became a Problem

Patrick is 58, a mechanic, presenting with exertional chest tightness. Clear cardiac risk factors: smoking, hypertension, family history. Examination unremarkable. ECG shows... well, I thought it looked normal, but I'm still learning. Dr O'Brien reviews it, agrees it's normal, reassures Patrick, arranges outpatient exercise tolerance testing.

As Patrick's standing to leave, the AI alert flashes: "Possible unstable angina, consider urgent cardiology review." We both stop. Re-examine the ECG together. Dr O'Brien still thinks it's normal. I certainly can't see anything. But the computer says otherwise.

Here's the dilemma: if we ignore the AI and Patrick has an MI tonight, what happens medico-legally? Conversely, if we refer everyone the AI flags, are we practising medicine or practising defensive medicine?

Dr O'Brien chose to phone the on-call cardiologist, explained the situation honestly, "AI has flagged this but I'm not convinced", and the cardiologist agreed to see Patrick in rapid-access chest pain clinic within 48 hours. He had a completely normal workup. But Patrick spent two days terrified he was having a heart attack, took time off work he couldn't afford, and now views Dr O'Brien with slight suspicion, as if she doesn't trust her own judgment.

The AI was wrong, but being wrong cost us something.

The Deeper Questions Nobody's Answering

The cases I've described raise questions that go beyond diagnostic accuracy. During a teaching session with Dr O'Brien, I asked her the question that's been bothering me: "Am I actually learning clinical reasoning, or am I just learning to follow algorithmic recommendations?" She didn't have a good answer, and I don't think anyone does yet.

There's substantial research on clinician acceptance of AI-CDS. A European survey of 842 primary care physicians found 70% expressed willingness to use AI recommendations when adequate training was provided and systems integrated seamlessly with existing EHRs.(5) However, barriers included liability concerns (64% worried about responsibility for AI-generated errors), inadequate reimbursement for time reviewing outputs (51%), and scepticism about algorithm transparency, the "black box" problem where we can't understand how the AI reached its conclusion (48%).(5)

That last point resonates strongly. When I ask the AI system why it flagged something, I get statistical probability scores, not clinical reasoning. "Patient has 73% probability of sepsis based on multivariate analysis of vital signs and laboratory parameters." What does that mean? Is 73% high enough to admit? Would I make the same call without the AI telling me that number? I genuinely don't know anymore.

What About Patients?

We talk a lot about what AI means for doctors. We talk less about what it means for patients. During a quiet moment in clinic, I asked Dr O'Brien whether patients know when AI is involved in their care. She admitted it's inconsistent, sometimes mentioned, sometimes not, depending on how rushed the consultation is. This troubles me. The Data Protection Commission Ireland mandates explicit patient consent for processing health data through automated systems, yet I've watched consultations where algorithms influenced clinical decisions without patients being informed.(6)

One afternoon, an elderly patient, Mrs Kavanagh, who's been coming to the practice for 40 years, asked Dr O'Brien directly: "Is a computer telling you what's wrong with me?" The question was loaded with anxiety. Dr O'Brien handled it beautifully, explaining that the computer helps analyse test results but she makes all final decisions. Mrs Kavanagh seemed reassured, but I wondered: was that explanation entirely honest?

Trust is the foundation of general practice, especially in rural communities where the same doctor may care for families across generations. If patients feel they're being diagnosed by algorithm rather than by someone who knows them, something fundamental is lost.

The Irish Context: Infrastructure Meets Reality

None of this works without basic infrastructure, and that's where rural Ireland struggles profoundly. Dr O'Brien's practice broadband drops multiple times daily. National Broadband Progress reports show rural counties average 68% broadband coverage compared to 94% urban coverage. Cloud-based AI systems are useless when the cloud isn't accessible.

I've watched consultations interrupted mid-flow because the system froze. I've seen Dr O'Brien complete entire consultations on paper because the electronic record wasn't loading.

What Happens When It Goes Wrong?

Medical defence organisations haven't yet developed clear guidance on AI-related liability. The Medical Council of Ireland guidance clarifies that GPs retain ultimate accountability for diagnostic and treatment decisions regardless of AI system involvement.(7) That protects patient safety by ensuring human oversight, but it means doctors carry full liability for AI errors.

Let's say an AI system fails to flag a serious condition, or flags something incorrectly prompting harmful investigation. Who's responsible? The doctor for trusting the AI? The software company for faulty algorithms? The HSE for implementing inadequately tested systems? Nobody really knows.

What worries me most is the asymmetry: AI companies face minimal liability (software typically comes with disclaimer clauses limiting responsibility), whilst doctors face full professional and legal accountability. That doesn't feel like a partnership; it feels like doctors assuming all the risk for tools they didn't design and don't fully control.

Could This Actually Work? Making It Better

Despite my reservations, I don't think AI in general practice is inherently bad. I think we're implementing it badly. If I were designing this (and obviously I'm just a medical student, so what do I know), here's what I'd change:

Start with Infrastructure

We cannot deploy sophisticated AI systems in practices with unreliable broadband. The National Broadband Plan aims for minimum 100Mbps connectivity to all premises by 2026, but healthcare facilities need priority acceleration.

Train Us Properly

I've received exactly zero formal teaching on AI-CDS interpretation during medical school. The ICGP should develop accredited training modules covering AI-CDS interpretation, limitations recognition, and maintaining clinical reasoning skills whilst using decision support. Make it mandatory for GP trainees. Include it in undergraduate curricula.

Test It Properly in Irish Populations

Most AI systems were trained on non-Irish data. We need rigorous pilot studies evaluating performance specifically in Irish rural general practice before national rollout. Select practices across Mayo, Kerry, Donegal, Galway, Wexford, representing geographic and demographic diversity. Provide fully funded AI-CDS systems, infrastructure upgrades, and implementation support over 12 months. Measure diagnostic accuracy, consultation duration, referral rates, patient satisfaction, GP confidence scores, and alert burden. If systems don't perform well in Irish contexts, don't deploy them nationally.

Create Support Networks

Dr O'Brien is pioneering AI-CDS use in rural practice essentially alone. The RCGP ROI Faculty should establish quarterly AI-CDS user forums, virtual initially, given geographic spread, enabling practitioners to discuss cases, troubleshoot problems, and build collective expertise.

Be Honest About Uncertainty

We need clear communication that AI-CDS is experimental, imperfect, and evolving. Don't oversell it to doctors or patients as infallible. Create explicit pathways for reporting errors, near-misses, and unintended consequences. Establish an AI Ethics and Governance Subcommittee within the RCGP ROI Faculty comprising GPs, ethicists, patient advocates, data protection specialists, and HIQA representatives. Make patient information sheets explaining AI involvement in care, written in accessible language, available in multiple languages reflecting Ireland's diverse population.

Make It Actually Useful

The AI-CDS systems I've seen focus heavily on diagnostic alerts, flag possible MI, possible sepsis, possible PE. That's valuable, but it's not where rural GPs spend most time. What would genuinely help? AI assistance with identifying which patients need chronic disease reviews, flagging medication interactions in complex polypharmacy before prescribing, triaging referrals by genuine urgency when waiting lists are long, and generating patient-friendly explanations of diagnosis and treatment.

Where Do We Go From Here?

I'm writing this essay three months into my GP placement. In that time, I've seen AI-CDS prevent one probable MI, prompt earlier antibiotic treatment for two sepsis cases, and generate four false-positive alerts leading to unnecessary investigations. I still can't confidently read ECGs without checking what the algorithm thinks first, which worries me.

Here's what I know: rural Irish general practice is struggling. Over 700 GPs will retire in the next five years, replacement rates aren't keeping pace, and patients are suffering. AI clinical decision support offers genuine potential to extend diagnostic capabilities when specialist access is limited. But potential isn't the same as reality.

The pathway forward requires honest acknowledgement of both promise and peril. We need better infrastructure, proper training, rigorous local evaluation, clear liability frameworks, and patient involvement in decisions about AI implementation. We need to preserve the relational core of general practice, trust, continuity, knowing patients as people rather than data points, whilst selectively incorporating technology that genuinely helps.

Most importantly, we need to train the next generation of GPs (my generation) to use AI tools critically rather than reflexively, to understand their limitations, and to maintain independent clinical reasoning even when algorithms suggest otherwise. The goal shouldn't be creating

doctors who follow computers; it should be creating doctors who collaborate intelligently with computational tools whilst never forgetting that medicine remains fundamentally human.
I don't know whether Mr B, the farmer with the subtle STEMI, would have been diagnosed without AI-CDS. Maybe Dr O'Brien would have spotted it. Maybe I'll develop the expertise to spot it in future. Or maybe the algorithm caught something we genuinely couldn't see, and that's okay. Medicine has always incorporated tools that extend human capability, stethoscopes, X-rays, blood tests. AI is another tool. A complicated, imperfect, occasionally brilliant, frequently frustrating tool.

Three days after Mr B's angioplasty, I saw him walking through Ballyvaughan with his wife, heading to the pub. He waved. That mattered more than any algorithm.
2896 words

“Essays are considered as original pieces of work, and confirm this with a statement confirming no plagiarism or use of AI”

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Commendation Winner - Sheppard Memorial Essay Competition 2025

The Silent Epidemic in the Waiting Room

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When Care Meets Fear

The waiting room is tense. A man's voice rises, sharp with frustration, as he slams his hand on the reception desk. His prescription has been refused, and the receptionist, who has no authority to alter the General Practitioner's (GP's) decision, forces a steady tone as she tries to calm him. Behind the glass she presses the panic button with a trembling hand, willing it not to be needed. In the consulting room nearby, the GP pauses, the familiar knot of unease tightening in her stomach. How close is the danger this time?

Scenes like this are not unusual. In the United Kingdom more than four in five GPs report verbal abuse each year, and nearly one in four have experienced physical violence[1]. In Ireland, official reporting systems list aggression as the leading cause of harm to healthcare staff, yet general practice remains largely invisible within those figures[2]. The only national survey of Irish GPs was published almost three decades ago, when one in five reported violent incidents[3]. The absence of more recent data is striking, and it raises a troubling question: has the problem grown in silence, accepted as part of daily practice without the scrutiny it deserves?

Violence in general practice is often dismissed as unavoidable, the price of being on the frontline of healthcare. Yet to accept it as inevitable is to overlook its deeper meaning. Each threat, each insult, each clenched fist represents more than an occupational hazard. It is a rupture in the covenant of trust that defines primary care, where patients and providers meet not as adversaries but as partners in health.

This essay argues that violence in Irish general practice represents a hidden epidemic: under-measured, under-reported, and under-addressed. It will examine why GP surgeries are particularly vulnerable, explore the consequences for staff, patients, and the profession, and highlight the stark absence of Irish data. Drawing on international literature and emerging policy, it will consider practical steps and propose a framework for safer practice. At its heart, this is not only a question of staff protection. It is a moral responsibility to safeguard the soul of general practice itself.

The Violence We Count and the Violence We Do Not

Violence in healthcare has long been recognised as a global issue, yet recent evidence suggests that general practice faces particular exposure. Surveys across the United Kingdom reveal that more than four in five GPs have endured verbal abuse in the past year, and nearly one in four have suffered physical assault[1]. These numbers do not sit at the margins; they represent the daily reality of thousands of surgeries where aggression has become part of the fabric of frontline care.

Reception staff absorb much of this hostility. They manage the blocked phone lines, the overbooked diaries, the denied prescription requests. International studies describe abuse directed at receptionists as so frequent that it is often labelled "routine"[4]. Words become weapons that leave no visible trace but steadily chip away at confidence and wellbeing.

In Ireland, the scale of the problem is harder to measure. The only national survey of violence against GPs was published in 1997, when one in five reported threats or abuse, and a smaller number described physical harm[3]. Almost thirty years have passed since then, during which the pressures on primary care have intensified, yet no comprehensive follow-up study has been conducted. The gap between that snapshot and today is a silence that speaks volumes.

Official data hint at the scale but obscure the detail. Internal reporting within the Health Service Executive consistently identifies violence and aggression as the leading cause of harm to healthcare staff[2,5]. However, these figures rarely distinguish between hospitals, community services, and general practice. The result is that incidents within GP surgeries disappear into broader statistics, invisible to policymakers and the public alike.

Globally, the World Health Organization has described workplace violence in healthcare as a public health emergency that undermines both staff safety and patient care[6]. Systematic reviews confirm that risk factors are recurrent: long waiting times, resource shortages, unmet expectations, and disputes over prescriptions[7,8]. Each of these is familiar to Irish general practice, where workforce shortages and system delays are now routine[9,10].

Taken together, the evidence paints a troubling picture. Violence in general practice is widespread internationally, insufficiently measured in Ireland, and dangerously close to being accepted as part of everyday work. It is a hidden epidemic that demands recognition before it is normalised beyond repair.

Why the GP Surgery Becomes the Lightning Rod

General practice is the most familiar door into the health system. It is the place where patients first bring their fears, where everyday illness is managed, and where the need for referral or reassurance is decided. This central role gives it a unique strength, but it also places staff directly in the path of frustration when expectations are unmet.

Receptionists are often the first to encounter this frustration. They are tasked with enforcing rules they did not write: turning patients away when appointments are gone, declining late prescription requests, and explaining why a referral cannot be expedited. In these moments, anger meant for the system finds its outlet in the person behind the desk. One receptionist described her role as "being a lightning rod for other people's storms." That description captures the imbalance that those with the least authority face the most hostility[4].

The design of GP surgeries compounds this vulnerability. Unlike hospitals with visible security, surgeries are often located in small buildings on ordinary streets. Waiting rooms are open, reception areas are exposed, and staff may work alone in consultation rooms without immediate backup. These features were intended to make general practice accessible and approachable. However, when trust breaks down, the very qualities that make surgeries welcoming can make them unsafe[11].

System pressures intensify the risks. Ireland faces a growing GP workforce crisis, with rising patient lists and long waiting times[9]. Each delay, each refusal, each boundary enforced can feel to patients like another barrier in a system already stretched thin. International studies consistently link these stressors to episodes of aggression in general practice[7,8]. What might begin as understandable frustration can escalate into confrontation when resources are scarce and communication falters.

Violence in GP surgeries is therefore not random. It emerges from a confluence of roles, environments, and pressures unique to primary care. Understanding this context is essential as without it, efforts to prevent violence will remain superficial, addressing symptoms rather than causes. To make surgeries safe, we must acknowledge why they have become vulnerable in the first place.

Bruises Seen and Unseen

The effects of violence in general practice extend far beyond the immediate outburst. A raised voice or clenched fist may pass quickly, but the unease it leaves behind lingers long after the waiting room has emptied. Staff who experience repeated hostility describe the same pattern of anxiety before each shift, dread at the sound of a raised tone, and the slow erosion of confidence. The harm is cumulative, not always visible, and often carried in silence[5,12].

For GPs, the toll can be decisive. Exposure to aggression contributes to burnout and early retirement in a workforce already stretched to its limits[9]. Younger doctors may weigh their career choices and conclude that a profession marked by fear is not worth pursuing. The irony is stark: the very people who enter general practice out of commitment to continuity and care may leave it because continuity of abuse makes the work unbearable.

Moreover, patient care suffers too as consultations shaped by fear are rarely conducive to openness. A GP who is on edge may hurry interactions, avoiding sensitive discussions that could provoke tension. Receptionists who expect hostility may soften boundaries, allowing inconsistent rules that undermine fairness[4,11]. In this way, aggression corrodes not only staff wellbeing but also the quality and equity of care patients receive.

The wider moral consequence is harder to quantify but no less real. General practice is built on trust in a relationship where patients can bring their vulnerabilities and expect compassion in return. Violence tears at this covenant by shifting the surgery from a place of safety to a place of apprehension, altering the tone of encounters and undermining the values that sustain the profession[6]. A waiting room should feel like a threshold to healing, yet for many staff it has become a place where they brace for confrontation.

The bruises of violence are not only physical. They are carried in the hesitant smile of a receptionist, in the defensive posture of a GP, and in the unspoken calculation of risk that shadows everyday care. If left unchecked, these hidden wounds threaten to reshape the very identity of Irish general practice.

Ireland’s Silence: When Not Measuring Becomes Normalising

Perhaps the most revealing feature of violence in Irish general practice is not what has been recorded, but what has been left unmeasured. The last national survey on this subject was published in 1997, when one in five GPs reported violent incidents, most of them verbal threats or abuse and a smaller number describing physical harm[3]. Almost thirty years have passed since then. In that time, the pressures on primary care have multiplied with larger patient lists, more complex chronic disease management, and a worsening workforce shortage. Contrastingly, no comprehensive follow-up study has been undertaken.

This silence is not neutral. Without data, the scale of the problem remains invisible to policymakers and professional bodies. Reporting systems within the Health Service Executive consistently rank violence and aggression as the leading cause of harm to healthcare staff[2,5]. However, these figures rarely separate general practice from hospitals or other community settings. The reality of aggression in small surgeries is submerged in broader statistics, leaving staff unprotected and policymakers without a mandate for change.

International comparisons sharpen the contrast. In the United Kingdom, repeated national surveys have mapped the prevalence of violence against GPs and informed interventions such as zero tolerance campaigns and designated services for violent patients[1,7]. Scandinavian countries have incorporated detailed reporting into occupational health systems, using this evidence to redesign practice environments with safety in mind[8,11]. Ireland, on the other hand, has allowed nearly three decades to pass without updated evidence. The result is a policy vacuum in which violence in general practice is at once widespread and neglected.

The absence of data carries a deeper danger: normalisation. What is not measured can too easily be accepted as routine, endured quietly by staff who feel there is no point in reporting what no one is counting. Each incident unrecorded becomes part of an invisible ledger, and silence risks becoming complicity[12].

Acknowledging this gap is more than an academic exercise. In fact, it is the first step toward change. If Ireland is to confront violence in general practice, it must begin by bringing visibility to the problem. Only then can solutions move from anecdote to policy, and from policy to protection.

Stepping Away from the Panic Button and Towards a Framework of Safety

Confronting violence in general practice requires more than goodwill or resilience. It demands a deliberate framework that protects staff, reassures patients, and affirms that aggression has no place in healthcare. International examples show what is possible, but Ireland has the opportunity to shape its own response.

Policy and accountability. In the United Kingdom, violent patient schemes allow practices to redirect persistently aggressive patients to specialised services where care is delivered under added security. Zero tolerance campaigns, backed by legislation, have made clear that violence is not part of the job[1,7]. Ireland lacks an equivalent policy. Establishing a national mechanism to support practices in managing repeat offenders would remove the burden from individual GPs who currently face these dilemmas in isolation.

Safe environments. The design of surgeries can either expose or protect. Secure reception areas, discreet panic buttons, and consultation rooms with clear exits are already standard in some European countries[11]. In Ireland, many GP surgeries occupy older buildings not designed with safety in mind. Investment in environmental redesign is not cosmetic but essential, allowing surgeries to remain welcoming while providing staff with reassurance that they are not defenceless[13].

Training and aftercare. Policies cannot prevent every incident. Staff need practical skills in de-escalation and conflict management, and they need support when incidents occur[5,6]. Regular workshops, peer debriefings, and access to counselling can help staff feel prepared rather than abandoned. A culture of open reporting, free from blame, would ensure that every incident contributes to learning rather than silence[12,14].

Community partnership. Violence in healthcare is not only a professional problem but a social one. Public campaigns that highlight the pressures on primary care and promote respect for staff can shift community expectations. Involving patient participation groups in designing these messages may strengthen trust and mutual responsibility[9,10].

An Irish framework for safe practice. The most powerful response would be to bring these strands together into a single, GP-led framework for safety. Such a framework could combine policy support, environmental standards, staff training, and community engagement, tailored to the realities of Irish general practice. Crucially, it would be proactive rather than reactive, aiming not only to respond to incidents but to prevent them.

Violence in healthcare is complex, but it is not inevitable. By committing to a comprehensive framework, Ireland can protect its general practice staff and restore surgeries as places of trust. In doing so, it would send a clear message that care can only flourish in safety.

Reclaiming the Waiting Room as a Place of Welcome

At its best, general practice is not defined by walls or waiting lists but by relationships. It is the surgery where a child receives her first vaccination, the room where a young man speaks of his anxiety for the first time, and even the desk where an older patient collects a prescription and chats about the weather. These everyday encounters are not small. They are the threads that weave trust between doctor, staff, and community.

Violence threatens to unravel this fabric. A waiting room that once felt like a place of welcome can become charged with apprehension. Each incident, whether shouted insult or clenched fist, erodes the unspoken covenant that patients will be met with respect and that staff will be safe in offering care. The risk is not only to physical safety but to the moral character of primary care itself[6,12].

To reclaim the GP surgery as a place of trust requires more than security systems or policies. It requires reaffirming the principles that make general practice distinctive, that being, continuity, respect, and compassion[15]. Staff must know that their wellbeing is valued as highly as the patients they serve. Patients must experience the surgery not as an arena of conflict but as a shared space of care, where frustration can be voiced without tipping into hostility.

This vision is not naïve. It recognises that illness, delay, and scarcity of resources will always create tension. However, it insists that aggression need not define these encounters. The surgery can remain a sanctuary of trust if violence is addressed openly, measured honestly, and met with determined solutions. By confronting the reality of aggression, Ireland has an opportunity to defend not only the safety of its healthcare workers but the very essence of community medicine.

Protecting Those Who Protect Others

Imagine that receptionist ten years from now. She greets a patient with calm assurance, supported by clear policies, protected by thoughtful design, and reassured by a culture that no longer accepts abuse as an unavoidable part of care. The knot of dread that once gripped the GP nearby has loosened. The waiting room feels once again like a threshold to healing.

Violence in general practice is not an isolated misfortune. It is a hidden epidemic that undermines the safety of staff, corrodes the trust of patients, and threatens the very ethos of primary care. In Ireland the problem has been made invisible by a lack of data and muted by the silence of underreporting. But silence is not safety. It is complicity.

The evidence is clear, the consequences profound, and the solutions within reach. Ireland can measure what has long been ignored, invest in safe practice frameworks, and foster a culture where compassion is matched with protection. In doing so, it can restore surgeries to their rightful place at the heart of the community.

This is not only a question of occupational health. It is a moral responsibility. If primary care is to remain the foundation of Irish healthcare, it must be a place where trust is stronger than fear and where healing can unfold without threat. The call to action is simple but urgent: to protect those who protect others and to ensure that the covenant of respect at the heart of general practice is not broken.

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Commendation Winner - Sheppard Memorial Essay Competition 2025

Sitting With Death: Presence as Practice in End-of-Life Care

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Introduction

Throughout the many communities and cultures of the world there is a profound acknowledgement and appreciation of the concept of a Trinity. Christians speak of the Father, the Son and the Holy Spirit. The Celts worshipped Maiden, Mother and Crone. The ancient Egyptians conveyed the Osirian trinity of Osiris, Isis and Horus. As worldviews merge and evolve, we hold within us the universal idea of ourselves as composed of body, mind and soul.

Modern medicine is mastering management of the body. We are intricately aware of the anatomy, physiology, pathophysiology and pharmacology of the human organism. This allows for interventions that improve physical care like never before. The mind is being mapped by the fields of psychiatry and psychology. Even though its inner workings remain less accessible than those of the body, progress is being made. Today, medicine can offer better care for mental illness than even a generation ago.

However, there is a third part of us that remains unseen by the clinical lens. This is an unapologetically elusive piece to the puzzle. It is not the body nor the mind, but the quiet unspoken essence beneath both - the elusive *presence* of the person. This presence is the space between thought and action, between identity and form. It has long eluded diagnosis, prognosis and even death itself. This may be why medicine has so far, ignored its existence.

In this essay I intend to explore the elusive spiritual principle of presence as articulated by Ram Dass when he urged us to “be here now” (Dass, 1971) and Eckhart Tolle who encourages us to “surrender to what is” (Tolle, 1999). I wish to understand how it may be meaningfully integrated into general practice, specifically the role of general practitioners in co-ordinating quality end-of-life care. I will draw on personal experience from both life and clinical placement and engage with literature on clinical training, palliative care and contemporary thought on spirituality and presence.

The healthcare system is increasingly being driven toward technological integration and cure-oriented goals. Yet, there is a case to be made that presence deserves to be woven into the ethical and clinical duties of physicians. I believe the intersection of general practice and palliative care offers fertile ground for this idea, where long-standing relationships and continuity of care create space for presence to guide end-of-life decisions. Here, presence can serve as a third mode of care, neither curative nor terminal, but relational and spiritual. This presence aligns with the concept of *Atman* in Vedanta, *Buddha-nature* in Zen and *the still small voice* in Christian mysticism. It is best described in a clinical context by nurse Lorraine Wright who attended an Eckhart Tolle retreat and described how he "drew us into a relationship with him by first having us experience silence" (Wright, 2015).

As a medical student, a practitioner of Zen and someone who has sat with loved ones in their final days, I have felt the quiet but unmistakable power of presence. This leads me to my question: What if the essence of end-of-life care in general practice is not found in medical interventions, but in the steady, relational act of simply being with another?

General Practice as a Place for Relational Palliative Care

The World Health Organization defines palliative care as a process involving "early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (Best *et al.*, 2020). The practice of end-of-life care was initially called 'terminal care' before being changed to palliative care in 1973. To palliate means to improve the quality of something and the name, which we have kept to this day, was picked intentionally because of this etymology (Pastrana, 2008).

Cicely Saunders created the Total Pain Model which built upon the above definition of palliative care by acknowledging the interplay of all the domains involved in a dying patient's suffering. The Total Pain Model asserts that pain is not merely physical and emphasises the emotional, social and existential distress that may add to the pain and suffering of a dying patient. It has been asserted that this model "originated from the developments of spirituality in palliative care" and that the inclusion of spirituality in the domains of suffering was a means to connect all aspects of life and "expand into each dimension of the human being" (Miccinesi *et al.*, 2020).

The central tenets of palliative care are to respect patient autonomy in decision-making, to preserve the dignity of the patient, and to offer compassion instead of correction. Interventions are driven by "the needs of the patient and family" (Fairman *et al.*, 2016). It is because of these tenets that Ira Byock wrote in his book *'Dying Well'* that good palliative care should "listen more than it advises" and offer emotional availability at all times (Byock, 1997).

Traditionally, the physician's role in palliative care has focused on pain management and symptom control. In contrast, general practitioners who have continuity of care and develop lasting relationships with their patients are uniquely positioned to offer emotional presence and facilitate meaningful end-of-life conversations. A paper about advance care planning in general practice noted that "in medical consultations, patients often express their emotions implicitly as cues". These subtle signals often go unnoticed unless met with attentive presence. By recognising and responding to these cues, the general practitioner brings the patient's emotional needs into focus and places their best interests at the centre of the conversation. This capacity for attunement is "a key feature of patient-centred care" (De Vleminck *et al*., 2023).

Saunders' Total Pain Model is pointing towards the emerging understanding that emotional and existential accompaniment is a crucial component of the clinical responsibility. This duty is already being heavily acknowledged in research about palliative care. One study on spiritual care in palliative practices noted that among the barriers to the provision of care in this domain were a lack of appreciation of the need for spiritual care and an inability to effectively provide it (Best *et al*., 2020). Another article highlighted that general practitioners often feel ill-equipped to handle the emotional and spiritual aspects of dying due to a lack of training in communication skills with a specific focus on palliative care at any point in their careers (Slort *et al*., 2011). A cross-sectional survey of graduate entry medical students cited Ireland as ranking one of the highest for palliative medicine education in Europe. However, this strength is not evenly felt by all. A curriculum review from the same survey found that 10 out of 11 key aspects of palliative care were deemed insufficiently covered by students. This included particular gaps in patient-centered work (Larkin *et al*., 2024).

The above research highlights a pressing need to enhance education across all levels of training in emotional and spiritual communication, particularly in general practice as this is the place where relational palliative care can most easily occur. Saul J. Weiner in his book 'On Becoming a Healer' stated that it would take "sufficient grounding and curiosity" to at least acknowledge to ourselves, where we are in our "journey to becoming healers" (Weiner, 2020). From my own experiences I would assert that when we strip back all of the layers of this spiritual and emotional communication, we find presence at its core, and it is this presence that I feel necessary to bring on my journey. This raises my next question; should physicians be trained in presence and not just protocols?

Training in Presence: A Clinical Imperative

Across world cultures, diverse spiritual traditions have used language and ritual to approach the 'unknown', the realm beyond death. With so many languages and ideologies, this experience is named and shaped in countless ways, each one refracted through the cultural lens of its people. There is however a common perception that it is through practicing presence that these experiences reveal themselves to us.

In Buddhism this presence is found through the acknowledgment and acceptance of impermanence. This is summed up by the word *Annica* which points to the impermanence of life and the self. Annica asserts that life is uncertain, and death is certain. From this lens, death is not feared but rather accepted as a natural transition, and clinging to a perception of permanence would only bring about suffering both in life and in dying.

Indigenous and pagan traditions like those of the Native Americans and the Celts placed emphasis on death as part of nature's cycle rather than as an endpoint. The indigenous and pagan rituals displayed reverence to their ancestry by connecting ideas of death with lineage and land. In these communities the Shamans and Druids were not just healers but guides, holding space for the living and dying. Just as in the case of Buddhism, this perspective sees death not as a finality, but a return.

Every patient and clinician alike will hold beliefs about death, some theological, some symbolic and some simply emotional. For general practitioners whose relationships with patients often span years or decades, providing truly compassionate end-of-life care means more than tolerating diverse views, it means holding space for them. Not just through referrals to chaplains or psychologists, but through their own presence. A qualitative study in 2011 interviewed palliative care patients and revealed that what they want are “friendly and committed GPs who take the initiative in discussing end-of-life issues” (Slort *et al*., 2011). In the context of death, *being with* matters more than *doing to*. This should form the foundation for any end-of-life conversation. Training in presence, from this lens, becomes not only a spiritual virtue but a clinical responsibility.

The Tension Between Death and Modern Medicine

Atul Gawande wrote about how modern medicine has become uneasy with the limits of the body (Gawande, 2014). Healthcare teams may unintentionally prolong suffering in the name of offering options. When a cure is no longer possible, curative intentions can become counter-therapeutic and the “turning point” toward palliative care can often come too late and at an unfortunate cost to the spiritual wellbeing of the patient (Hov et al, 2020). The actions of medical professionals, though well-meaning, must be carefully considered. The drive to heal is often life-saving, but when dying is inevitable, that same instinct can delay death and in doing so risk treating it as a failure, rather than the natural course of life. Gawande highlights this danger when he writes "our interventions may extend life, but they do not always preserve living" (Gawande, 2014).

This theme echoes widely in modern end-of-life research. One such example is a review on palliative care in gastro-intestinal malignancies which found that inadequate spiritual care is associated with worse outcomes often due to more aggressive end-of-life measures or lower hospice usage amongst patients seeking this type of care (Mercier *et al.*, 2023).

I have witnessed this tension in real life, both during observerships and in the recent death of a family member. When death is approaching and all of the signs are there, I have seen how easy it is for patients, loved ones and medical professionals to lose their presence while searching for the ‘right' thing to do. What I have felt is not just a tension within medicine, but a tension within myself as a medical student, a loved one and a human being.

The Stillness of Death: A Personal Encounter

My grandad kept active throughout his retirement. We would regularly go to his farm together and look after the sheep, doing jobs such as herding, shearing, dosing and lambing. All of these tasks required intense physical strength and stamina which he possessed until late into his 80’s. He was hopping over iron gates with more of a spring than me, even at that age. It is hard to pinpoint exactly when it happened, it was, like all other things, probably a gradual process, but it appeared as though one day all of a sudden, we wouldn’t be going to the farm anymore. But even when he felt unable for the manual labour that he loved so much, he employed his mind toward writing about his hometown, the land, the people and the farming. He began publishing books and short stories in both English and Irish, tapping away at his laptop from the comfort of his living room. I would often be called in to help him figure out how to do something on Microsoft Word and afterward we would have a cup of tea and discuss religion, spirituality and farming. He would then send me home with a book by Eckhart Tolle or Yuval Noah Harari, or at the very least with a new angle to consider about life and death.

Just like with the farming, there was an unnoticeably gradual decline in his interest for writing and reading. It was as if one day I went to visit him and he had taken to the bed. We went in and out of hospitals for acute treatment and physical rehabilitation, and this seemed to become the new normal. He wished to come home, and when he did, we arranged that there would always be someone to feed him and sit with him. He didn’t have much to say about anything at this time, we would sit in silent presence. My mind tended to rush, to think "he's not talking, I'll come back another time". But I resisted that impulse and chose instead to sit with him silently. He no longer had any interest in the TV, 'the Farmer's Journal' or conversation of any kind. So we sat, facing each other, exchanging the odd word sparingly here and there. It is impossible to know, but I believe at that time that he no longer had any interest in discussing religion or spirituality like we used to because he was now experiencing it, living it. He was fully present in the moment and process of dying, and I was aware that all I wanted to do while in his presence was be there with him in it.

Due to the progression of his condition, he once again had to return to hospital. This time was different. Previously he would have protested being in the hospital and looked around the ward impatiently waiting for his time to return home. But this time he rested quietly in the hospital bed. Just like at home, family would come in and out, checking things and helping however they could. I noticed that hospital staff would do the same, quick fleeting visits to ask a question to someone sitting by his bed or administer a drip and leave. The minds of my family were busy, and the schedules of the hospital staff were equally busy. He remained the centre-point of stillness around which everybody rushed. In the presence of his stillness I felt helpless and calm all at once. I was witnessing something sacred and sorrowful unfold, and as much as I wanted to, there was nothing left to fix. Then one day, as my gran got up to go home and say goodbye to him, he too departed.

Re-Imagining End-of-life Care

What I learned from my grandad's bedside will continue to inform how I understand my future role as a doctor. There can be no one-size-fits-all model for end-of-life care. Individuals make their own meaning, and society continues to diversify in belief, identity and worldview. One case that echoes this is that of a 39-year-old woman with terminal cancer who refused all conventional treatment in the hospital and instead asked for a silent and candle-lit devotional space to continue her meditation (Barham, 2003). This case study highlights that in the absence of a clear role for spiritual care, clinicians may feel unprepared and hesitant, fearing that they might cause harm or act beyond their remit. Most healthcare professionals are trained to follow predictable patterns and clinical algorithms, but death is a paradox that is universal and deeply personal at the same time. It is my belief that the use of non-judgemental, loving presence is the simple but powerful answer to this paradox.

In order to meet the growing diversity of need, we must find ways to help prevent spiritual care being overlooked. It has been noted that although spirituality is a recognised domain of palliative care, it is often the most neglected (Quinn and Connolly, 2023). This is in no small part due to the feeling of many clinicians that answers to spiritual distress lie outside the scope of modern medicine. It is my belief that it is the duty of all healthcare professionals to create space for the spiritual and emotional grief that is a necessary part of the final journey. As the first and most familiar point of contact for patients, general practice is the most accessible setting to offer presence and is therefore the most vital place for us to get it right. There is a growing database of literature supporting spiritual sensitivity in end-of-life care, but it is clear that the implementation is patchy.

On my general practice placement, I have witnessed doctors bridge the gap between theory and practice through simple, intentional presence. They created a space where meaning was felt and not just understood, where patients were seen and not just treated. I watched as patients left the consultation lighter, not only because of a plan or prescription, but due to this intangible form of healing. Being in the room for these moments furthered my understanding of what it means to heal and made me fall in love with general practice.

Conclusion

The central insight that I sought to write about is that true presence makes space for the sacred. In writing this essay I have come to believe that presence is not just a personal ideal but a clinical necessity in the context of death. Our role may not always be to cure, but it will always be to accompany, to listen and to be fully present. General practice offers the relational continuity to make this sacred offering possible. Ram Dass said, "loving awareness is the medicine we forget we know how to give" (Dass, 2014). As people, we need to give this medicine to each other a little more often than we do, and as healthcare professionals, it should be the background hum of every interaction we have. Among all domains of palliative care, the spiritual is the one we have yet to perfect, and I believe it starts with presence. To sit with someone in their final hours, not to fix but to simply be with, may be the most sacred act modern medicine can offer.

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Commendation Winner - Sheppard Memorial Essay Competition 2025

Navigating the Balance: Benzodiazepine and Gabapentinoid Prescribing in General Practice

Author: Hiya Grover, Undergraduate

“I’ve lost my prescription,” the woman said over the phone, her tone urgent. She was a known patient at the practice calling regarding her repeat medications. “It has the diazepam on it,” she added, no mention of her statin or antihypertensives. The GP paused, explaining gently that as diazepam is a controlled drug, she would need to report this to the police, obtain a reference number of the complaint, and then call us back before we could re-issue her medications. When the call ended, I thought the response seemed quite harsh and heavy-handed. However, the GP quietly noted that this was not the first time the patient had “lost” her prescription. Hours passed, and despite my optimism, the phone call never came. What I had initially interpreted as a routine administrative issue quickly unfolded as something far more unsettling; a pattern of behaviour which blurred the line between distress and dependence, trust and caution.

A week later, another patient sat before us, requesting gabapentin for his chronic neuropathic leg pain, explaining that it not only relieves his symptoms, but drastically helps him “calm down.” The GP noted he was already on long-term pregabalin after multiple unsuccessful attempts at tapering doses. With some hesitation, he admitted that he had been buying gabapentin illegally and found this more helpful – and produced a box with another person’s prescription label half scratched off. He described that the dealer had even taught him how to safely up-titrate the doses and when to seek help with signs of overdose. After an intense discussion about the risks of combining the two agents, a compromise was negotiated: a prescription for gabapentin for pain while withdrawing pregabalin, along with the promise hw would stop illicit drug use and attend his clinical reviews.

Encounters like this expose one of the most complex dilemmas in general practice in Ireland, throughout Northern and the Republic of Ireland (NI, ROI) – the tension between compassion and caution of benzodiazepine and gabapentinoid prescribing. This discussion explores the dilemmas of benzodiazepine and gabapentinoid prescription in general practice, prescribing trends, and considers how safe and compassionate care is trying to be upheld in an under-resourced system.

Benzodiazepines, namely diazepam and lorazepam, are centrally acting neurological agents that act on the benzodiazepine receptors by increasing the duration of chlorine channel opening, enabling the GABA neurotransmitter to hyperpolarise neurons, resulting in central nervous system depression(1). Another class of similar agents, gabapentinoids, act on calcium-mediated release of neurotransmitters which prevent transmission of nociceptive pain signals(2). Collectively, these agents, despite varying mechanisms of actions work to cause nervous system depression, with anxiolytic, hypnotic, anticonvulsant, and analgesic properties(1,2). In general practice, they are used for the short-term management of anxiety, insomnia, muscle spasms, acute agitation and neuropathic pain. Despite their therapeutic value, long-term use is a persistent, and growing concern in primary care, with dependence and withdrawal posing significant challenges to safe prescribing and discontinuation practices. When prescribed for protracted periods, 3-4 weeks, the risk of dependence, that is the biopsychological condition where the body adapts to the presence of a drug, and withdrawal – symptoms occurring when the drug is stopped, exponentially increases(3). These agents also downregulate inhibitory receptors, resulting in compensatory hyperexcitability, which leads to tolerance and the need for increasing doses to achieve similar therapeutic effects(3). Ultimately, withdrawal of such agents can lead to agitation, anxiety, pain, insomnia, and at times seizures(4). In primary care, where patients have complex presentations and various social, cultural, and financial stressors contributing to their holistic wellbeing, long-standing use of these agents and limited access to alternative therapies, lead to blurred boundaries between appropriate use and dependence, making discontinuation clinically and emotionally challenging for doctors and patients alike.

National guidelines acknowledge the risks of these medications and they are well-established in medicolegal literature in both NI and ROI. Guidelines surrounding gabapentinoids suggest they should not be used as first-line for chronic pain, and if used, should be monitored frequently for sedation, side effects, or co-use with alcohol or opioids – they are not to be re-prescribed without review(5). Similarly, benzodiazepines should be prescribed at the lowest effective dose for the shortest period, ideally <2-4 weeks, and need three monthly monitoring at a minimum(6). They are only licensed for long-term use in exceptional cases like treatment-resistant anxiety, end-of-life care, or epilepsy. They must also be tapered with caution as soon as permissible. Further, guidelines emphasise the use of early tapering plans and holistic management by integrating other psychological, physical, and social supports for patients reliant on these classes of medications(7,8).

Strong evidence highlights the harms associated with the excessive use of benzodiazepines and long-term prescriptions in Ireland. Chronic benzodiazepine use is closely linked to tolerance, dependence, severe withdrawal symptoms, cognitive impairment and falls risks(9). In ROI, despite the institutional guidance about short-term prescribing, population data continues to highlight persistent long-term use, polypharmacy and dependence in both psychiatric and primary care. Similarly, in NI, benzodiazepines remain implicated in a significant proportion of episodes of prescription drug misuse(10,11). Though gabapentinoids were considered a safer alternative, they are showing upward trends in misuse and dependence, patient harm and emergency presentations, specifically amongst vulnerable populations with polysubstance abuse(12). Although attempts are made through nationwide guidance and public health initiatives, the literature highlights the significant harm associated with overprescription, emphasizing the need for deprescribing strategies, regular review, and adherence to medicolegal guidelines.

Trends in benzodiazepine prescribing in Ireland are inherently complex and show a changing landscape rather than a uniform decline. Historically, benzodiazepine prescribing in the public sector rose, however, more recent data demonstrates a significant fall of these agents between 2005 and 2015, with a simultaneous increase in z-drug (z-hypnotic agents) prescribing(13). Contrastingly, gabapentinoids show a distinct pattern of an increase in prescriptions from 2010 to 2020, with an annual adjusted rate of increase of 1.06 and 1.08 per year for gabapentin and pregabalin, respectively(14). Alongside this, studies have found a recent increase in toxicology and law-enforcement data implicating their role in seizures, drug-related deaths, and post-mortem detection(14). Northern Ireland shows a worrying picture, regional reports show the ongoing high prevalence of benzodiazepines and pregabalin prescribing, legal and illicit misuse, and harmful polypharmacy(15). Benzodiazepines have been implicated in 46% of presentations of harmful substance use, and pregabalin is linked with approximately 38% of drug-related deaths in recent years(16). Patterns within these trends are significant – prescribing and subsequent harm are disproportionally concentrated in vulnerable populations including older adults, socioeconomically deprived areas, patients with multi-morbidity and those with histories of substance misuse. Both the UK and Ireland show higher benzodiazepine prescribing in general practices serving deprived populations, despite overall reductions in national initiation rates(12). Together, these suggest that the landscape of prescribing has undergone a paradigm shift to some extent, moving towards newer agents like gabapentinoids and replacement agents, ongoing long-term prescriptions, and regionally concentrated overprescription.

If we, as individuals, practitioners, and governance bodies, are aware of the dilemma and the implications for patients, why does it persist? Fundamentally, this reflects the social circumstances patients face, alongside an institutional breakdown underpinning a multifactorial issue.

In both ROI and NI, a persistent shortage of access to mental health and pain management services leads to the long-term and overprescribing of benzodiazepines and gabapentinoids. GPs report that when patients present with chronic pain, insomnia, or anxiety, the lack of community counselling services, cognitive behavioural therapy, or delays in secondary care input leaves medication as the quickest option. An Irish report quotes “at the heart of over-prescribing is often the patient with distressing symptoms” and alongside a systematic delay to get the timely help needed for these patients in line with evidence-based practice guidelines, GPs are left helpless(17). Further, socioeconomic stressors, and historical trauma which is so profoundly interwoven into the populations – including high rates of unemployment, deprivation, trauma exposure, post-traumatic stress disorder, and the post-pandemic burden on primary care, further amplify the demand for pharmacological relief during the wait for structural support.

Furthermore, workload pressures and fragmented service continuity contribute significantly to the overuse of these agents in primary care. GPs are under time pressures, with long waiting lists and ten- or fifteen-minute consultations and often face a "silver bullet" expectation from patients. Consequently, many consultations result in a prescription because of the resource and time limitations. Additionally, the evident disjointed connection between primary, secondary and ongoing mental health or chronic pain services, leads to a default persistence of long-term prescriptions of benzodiazepines and gabapentinoids when achieving systematic review, and early tapering is so difficult. Though inpatient initiatives to add tapering advice and timelines in discharge letters are initiated, the pragmatic limitations result in legacy prescribing. The cumulative burden of service shortfalls, patient distress, high GP workload, limited resources and care continuity creates an environment where GPs operate under significant constraint, and these agents become the default long-term solution rather than the short-term exception.

The triage note put on the list that morning said, "phone call: lost prescription?". A middle-aged woman was on the line, asking for a replacement of her diazepam prescription. She said she had lost it while shopping, curiously, she did not mention any of the other prescriptions on the script. The GP's response was honest and firm; to reissue, she would need a police issued reference number, and could phone us back to get a replacement. My first thought was that it seemed harsh, would the extra wait and phone calls lead to the patient missing her dose, becoming anxious, unwell, or not getting any sleep? Then the GP shared that this was not the first "lost" prescription for the patient. However, I quickly began to understand; the phone consultation was a balancing act between trust and safeguarding. The risks of benzodiazepines are well documented in literature, alongside the patterns of misuse, and risks of polypharmacy or overdose. Watching the GP explain the rules showed me the practical and emotional implications of trying to prevent harm to the patient and others, all while trying to uphold the therapeutic relationship. It made me reflect on the stress felt in these consultations, the rapid judgement calls, the critical insights, and the significant discretion GPs exercise on the daily, under immense time pressures and without immediate access to alternative services.

A few days later, a patient came in requesting gabapentin for his neuropathic leg pain. He admitted to taking long-term prescribed pregabalin and obtaining gabapentin illicitly, claiming it helped more with the pain while also calming him down and coping with anxiety. He even showed a box of this illicit gabapentin. The GP spent most of the consultation explaining the risks of mixing gabapentinoids and eventually reached a shared plan: switch the pregabalin to gabapentin under supervision, stop illicit use, refer to the chronic pain clinic, and monitor closely. I felt the GP's moral distress, wanting to help, recognizing the patient's benefit, and knowing the risk of serious harm that was implicated in the consultation. Extensive reports from primary care, emergency departments, and law enforcement services show the prevalence of misuse and overdose with these agents across Ireland. In that moment, I saw the true face of it. I realised how a distressed patient, often helpless and undersupported, and systemic pressures like overstretched mental health services, limited pain services, and fragmented care, pushed clinicians towards prescribing a practical, however imperfect, solution.

Both encounters, among many which I observed during my placement, made me acutely aware of the power dynamics and balancing acts in the consultation. GPs must constantly weigh patient autonomy and beneficence with non-maleficence: how much to trust, how much to insist, how much to safely give, and how much to risk. I noted my own reactions, empathy and concern for patients, frustration and anger towards the systemic limitations which were worsening with time, and admiration for the GP's invaluable insight and calm consultation. Literature evidently supports these tensions in the career as a primary care practitioner. Studies highlight that GP prescribing patterns reflect the ambivalence, ethical conflict, resource-based pressure, and reliance on benzodiazepines when non-pharmacological measures postulated in guidelines, are not available. This experience taught me that over- and long-term prescribing is rarely an act of negligence – at the crux of it is a complex interaction between patient distress, clinician responsibility, and structural limitations.

More subtle learnings became evident, too. Compassion fatigue is very prevalent in the profession; the GPs measured approach seemed somewhat protective – both for themselves and the patient. Patients seek relief from more than just physical symptoms: they come looking for help with anxiety, insomnia, chronic pain, or are vulnerable - living with socioeconomic stressors, hardship, and trauma. Prescribing here goes far beyond a clinical decision and instead becomes a negotiation with the patient's lived reality. Medically, both cases showed me the repercussions of systems that are not accommodating of safe tapering, shared care, or non-pharmacological interventions, leading to long-term dependence and risk-taking behaviour.

I understood that prescribing in general practice, especially with these agents, is a moral and practical tightrope. Each prescription carries consequences, in benefits, risks, and implications beyond the 10-minute consultation slot. Reflection on these cases truly highlighted the importance of structured protocols, continuity of care, and access to alternative therapies – as well as the human element of trust, empathy, and critical decision making from GPs.
From a broader perspective, the cases and literature show the ethical tension in general practice, balancing the pillars of autonomy, beneficence, and non-maleficence. While benzodiazepine and gabapentinoid use offer symptomatic relief, it becomes immensely difficult to justify the risks and harms which may arise from lengthy, unchecked prescriptions.

Encouraging tapering is clinically correct based on the scientific evidence-base but can sound coercive and feel paternalistic to patients. On the other hand, continuing legacy prescriptions because of empathy, or the fear of the patient deteriorating, can propagate further harm in the form of tolerance and dependence. GPs ultimately bear the weight of this ethical grey zone, where trying to minimise harm by maintaining patient stability, and preventing illicit use, may lead to an imperfect, pragmatic solution, as opposed to complete abstinence.

Such prescribing dilemmas reflect a systemic shortcoming and public health repercussions. Limited access to psychological therapies, chronic pain services, and social support across the island leaves GPs with limited alternatives. Short consultation times, heavy workloads, length waiting lists and fragmented communication between primary and secondary care further constrain the opportunities for deprescribing and regular reviews. Additionally, the political and socioeconomic landscapes that patients face create challenging expectations. Hence why, despite the push towards regular auditing, existing guidance by national healthcare regulatory bodies on benzodiazepines and gabapentinoids, implementation is inconsistent, particularly in deprived areas.

Is there a solution, though? It is definitely not as black and white as we would like, but practical solutions would require moving towards structured and collaborative care. Primarily, providing clear discharge advice from secondary care about tapering, regular standardised medication reviews – and allocated time for the same, shared decision-making, and honest conversations between doctors and patients, could help promote dose reduction, limit over- and de-prescribing. Improved collaboration between pharmacists, community services, and secondary care could also help evenly distribute responsibility between healthcare workers more evenly. Regarding public health and policy, an emphasis on expanding nationwide audits, integrating deprescribing into medical and speciality education, and targeting systematic barriers of unequal resource distribution further enable safe prescribing. Tackling such barriers will require both ethical sensitivity at the individual consultation levels, supported by systemic investments to create a safe environment for everyone involved.

The patterns of benzodiazepine and gabapentinoid prescribing in general practice are changing. While there may be a paradigm shift in practice in terms of neurological agents used and a possible nationwide reduction in prescribing, at an individual level and among the most vulnerable populations, the problems persist, and their repercussions on health are evident. GPs tread this moral and ethical tightrope daily, constantly battling with doing what is best for the patient, preventing harm, and doing what is truly practical within the constraints of a strained system. The cases described are just two among many, highlighting that at the crux of this issue is a distressed patient, coping with much more than just physical symptoms - coming to their GP for any form of help. It is a reflection of the burden on GPs, whose ability to act is often limited by time and resources, exposing deeper systemic limitations. Benzodiazepine and gabapentinoid prescribing in primary care are not a simple issue; it is interwoven with patient vulnerability, the socioeconomic conditions, and systemic barriers that prevent “quick-fix” solutions. In general practice, it persists as a problem requiring urgent attention because of its profound risks to patients, and the growing strain on primary care providers. Progress moving forward will be far from linear; it will depend on coordinated approaches between institutions, improved access to non-pharmacological services, standardised reviews and deprescribing practices, and a shared understanding about dependence. As a service, it must be acknowledged that the solution to tackling overprescription lies equally as much in the health system and social barriers, as in the prescription paper itself.

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Declaration: This essay is an original piece of work, no plagiarism or AI was used for this.

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Commendation Winner - Sheppard Memorial Essay Competition 2025

The Question Unasked: Sexual Abuse, Disclosure, and the GP

Author: Rhieya Rahul, Undergraduate

She came in for headaches. For the GP, it was a familiar presentation, one that fills consultations across Ireland daily. Questions flowed automatically: caffeine, stress, sleep, eyesight. She answered politely, but her eyes carried hesitation, drifting away from contact. Behind the guarded responses lay a story that no training had prepared the GP to uncover, a story that might explain not just the headaches, but her broader pattern of fatigue, recurrent infections, anxiety, and depression.

In general practice, such stories often remain untold. GPs occupy a unique position: frequently the first, and sometimes only, professional a patient trusts with their vulnerabilities. Yet when it comes to sexual abuse — a trauma affecting one in four women and one in six men globally (1), silence persists. Medical training equips doctors to inquire about smoking, alcohol, or family history with confidence, but the question of abuse is seldom asked.

This essay examines the gap between the prevalence of sexual abuse and GP preparedness to respond, arguing that disclosure training must shift from the periphery to the center of general practice education.

The Hidden Epidemic in Consulting Rooms

Sexual abuse is not rare. It walks through GP surgeries every day, often disguised as medically unexplained symptoms.

The SAVI report in Ireland found that 20.4% of women and 16.2% of men experienced contact sexual abuse during their lifetimes (2). European data suggest these figures may be conservative, with up to 25% of women and 16% of men experiencing sexual violence in adulthood alone (3). In a typical Irish practice of 2,000 patients, hundreds are likely to be survivors.

The consequences are profound. Survivors present higher rates of chronic pain, gastrointestinal issues, gynecological and cardiovascular problems (4), as well as depression, anxiety, PTSD, and substance use (5). Many arrive repeatedly with symptoms that resist diagnosis, leading to frustration for both patient and practitioner.

Yet fewer than 30% of survivors disclose their abuse to healthcare providers (6). When disclosure does occur, it often comes decades after the abuse. Every unasked question represents a missed opportunity for support and early intervention.

The GP Consultation: A Space of Potential

The GP consultation is uniquely positioned for disclosure. Continuity of care, trust, and comprehensive engagement create opportunities rare elsewhere in healthcare.

Research shows survivors often want GPs to ask about abuse, particularly when symptoms suggest trauma (7). However, they emphasize sensitivity: disclosure should feel safe, private, and genuine, not a checkbox.

Barriers lie primarily with GPs. Many feel unprepared to ask, uncertain how to respond, or anxious about the emotional and time demands of such conversations (8). While understandable, this caution perpetuates silence, leaving patients' hidden histories unacknowledged.

The Training Deficit

Medical education equips practitioners to identify murmurs, manage chronic disease, and screen for lifestyle risks. But preparation for handling sexual abuse disclosure is inconsistent or superficial.

An Irish study reported that only a minority of GPs felt confident asking about sexual abuse histories (9). Even experienced practitioners can experience anxiety: the fear of opening a wound that cannot be closed within the constraints of a ten-minute consultation. This hesitation can discourage disclosure, leaving the underlying trauma unaddressed.

International evidence suggests structured disclosure training changes this dynamic. Providers trained in trauma-informed care demonstrate improved confidence, better recognition of trauma-related presentations, and higher referral rates (10). Patients report increased comfort and trust with trained practitioners (11). Without similar training, Irish GPs risk missing critical opportunities for care.

Beyond the Individual: Systemic Implications

Failure to address disclosure has consequences beyond the individual consultation. Survivors of sexual abuse are at higher risk of chronic illness and mental health issues, which increases healthcare utilization and costs (12). Repeat presentations, unnecessary investigations, and unresolved symptoms are common.

Healthcare silence also reinforces societal stigma. When trusted professionals do not ask, it signals that abuse is unspeakable or irrelevant to health. The COVID-19 pandemic magnified these issues: reports of domestic and sexual abuse rose during lockdowns, while access to services diminished (13). In such contexts, the GP became a crucial, if often unprepared, point of contact.

Learning from International Models

Other countries offer valuable lessons in integrating disclosure training into primary care. In the United States, routine screening for Adverse Childhood Experiences (ACE) has enhanced recognition of trauma, increased provider confidence, and even helped reduce burnout (14). In Australia, the Royal Australian College of General Practitioners has developed detailed guidelines for identifying and responding to family violence and sexual abuse, offering scripted questions and clear referral pathways (15). Across the United Kingdom, several NHS trusts have introduced trauma-informed GP training that addresses not only practical skills but also practitioner wellbeing (16).

These examples illustrate that structured disclosure training is both feasible and effective and suggest that similar approaches could be adapted to the Irish context. While the HSE provides online modules on domestic, sexual, and gender-based violence, these often remain optional and theoretical. A more hands-on, practical, or mandatory approach might better equip Irish GPs to recognize and respond to disclosures with confidence, ensuring that training translates into meaningful change in the consultation room.

Survivors' Perspectives

Survivors often enter the consultation room carrying experiences that are deeply personal, painful, and sometimes shrouded in fear or shame. Many silently hope that someone will notice the signs, the tension in posture, the hesitancy in answering routine questions, the subtle cues in voice or expression and offer a question that feels safe to answer. They want to be asked, believed, and respected, not rushed or treated as a clinical formality. For them, acknowledgment is powerful: when a GP recognizes that symptoms such as chronic pain, gastrointestinal upset, or anxiety may be linked to past trauma, it validates their lived experience (17).

Negative experiences such as disbelief, awkward discomfort, judgment, or quick deflection to physical symptoms can have lasting consequences. Survivors may withdraw from future healthcare interactions, avoid sharing crucial information, and endure untreated symptoms (18). Ideal encounters are those where practitioners listen with attention and empathy, provide clear guidance on support options, and maintain professional boundaries while demonstrating genuine care. These interactions not only facilitate disclosure but also foster trust and begin the process of healing.

Practical Considerations

While implementing trauma-informed care presents challenges, practical solutions make it achievable. Sensitive inquiry need not significantly extend consultations; simple, carefully worded questions can create a space for disclosure while respecting time constraints, such as: "Sometimes when patients have ongoing symptoms like yours, they've experienced difficult events in the past. Has anything like that ever happened to you?" (19). The emotional impact on GPs must also be acknowledged, as hearing disclosures can be distressing. Training should therefore include strategies for self-care, maintaining professional boundaries, and accessing supervision or peer support to prevent secondary trauma (20). Accessibility is equally important: a combination of online modules, interactive workshops, and clearly defined referral pathways ensures that training translates into meaningful practice. Knowing where to direct patients after disclosure not only builds practitioner confidence but also enhances patient safety and the overall effectiveness of trauma-informed care (21).

Bystander Awareness in the GP Practice

Trauma-informed care extends beyond the GP consultation. Every member of the practice right from receptionists to nurses and administrative staff can play a role in noticing signs of distress and supporting disclosure. Bystander awareness, the practice of recognizing when someone may be struggling and acting appropriately, can transform a patient's experience. For example, a receptionist who senses unease in a patient waiting for an appointment could quietly offer extra privacy or provide information on support services. Similarly, practice nurses observing anxiety or avoidance during routine checks can alert the GP or gently encourage the patient to share concerns.

In the context of sexual abuse, these small, thoughtful interventions matter. Many survivors navigate consultations with fear, shame, or uncertainty about whether they will be believed. When the practice team demonstrates attentiveness and readiness to respond, it communicates a culture of safety and trust. Bystander awareness ensures that trauma-informed care is not confined to the consultation room but becomes part of the everyday environment, signaling to patients that the practice as a whole recognizes and supports those who carry hidden stories.

Medical Education: Early Integration

Undergraduate education offers the ideal point to embed trauma-informed skills. Early exposure normalizes trauma-sensitive practice. Simulation-based learning, with trained actors as patients, provides safe opportunities to practice disclosure conversations and receive feedback (22). Linking this training with modules on mental health, chronic disease, and communication underscores trauma's relevance across primary care.

Continuing professional development can address gaps for established practitioners who missed early training.

Conclusion: The Courage to Ask

The unasked question is more than a missed clinical opportunity; it is a moment to build trust and allow a patient's story to be heard. Silence persists not because patients are unwilling, but because the system is unprepared to listen. Comprehensive care is measured not by tests or prescriptions, but by the spaces created for human truth. Trauma-informed disclosure training is not optional, it is an ethical and professional imperative. Every patient, every “Sarah” with hidden pain, deserves the courage to ask. The question is no longer whether to act, but how quickly asking can become standard, not exceptional.

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Artificial Intelligence in General Practice

Author: Aisling Kelly, Undergraduate

By this day and age Artificial Intelligence (AI) has become one of the most heard of and prominent aspects of everyday life as a whole. Whether that is virtual assistants such as Siri, which play a significant part in the role of our mobile phones, or even the most simple things like the weather app to keep us updated on the feasibility of our everyday plans, artificial intelligence has become a huge part of our daily lives. You could almost say that it is something we could not live without and is one of the most praised inventions yet. This is a tool that is forever evolving and changing, allowing us to maximise our time and money so that we can move through life in the most efficient way possible. However, some people would argue that AI has become such a big part of our lives that it is almost too close for comfort. It may appear that it is encroaching into our personal bubble, as you may say, in that it may have too much control over things like our personal details, and even our likes and dislikes. Hence, due to the evolving nature that AI holds it is important to understand how this tool can be used for good in General Practice (GP) and whether it will meet all our expectations regarding benefits.

General Practice is a fundamental part of healthcare for patients and is often referred to as the cornerstone of healthcare for the community. There can be many moving parts for each patient who presents to clinicians which are interacting with each other and influencing one another. It is important that we recognise how challenging this can be, whilst also keeping an eye on chronic conditions that patients may have ongoing in the background. In addition, the vast majority of clinicians also have to undertake administrative work, whether that involves referrals, or medication management. Hence, the ability to utilise tools to help make these tasks more efficient would seem like a sensible thing to do. To fully understand how AI could be used in General Practice it is helpful to understand exactly what AI entails. This is a computerised tool used to complete tasks that would normally have needed human thinking to complete, for example, making decisions and carrying out administrative tasks. Hence, if we can use these tools to our advantage, within a GP practice, we may then be able to use our time and thinking more effectively so that we can improve patient care and satisfaction, overall leading to better patient outcomes.

AI can be used in many ways within primary care settings, including carrying out administrative tasks such as completing referrals and clinical notes, as well as triaging and booking patients by analysing the symptoms the patient describes and deciding what the patient would benefit from the most. Some of these tasks are reported by clinicians as being the most burdensome (1). Following an audit based on 23 symptom checkers which could be availed of by the public, it was found that advice was given at triage to 57% of these. However, in those cases which AI deemed as an emergency triage advise was given in 80% of these cases. Therefore, this could have meant that patients were seen at the emergency department or in other emergency settings in a faster time than if they had booked an appointment, which could have potentially saved vital life-saving time. On the other hand, in some cases where self-help advice was not given, when this was referred to the GP it was found that this appointment was not needed and that self-help advice would have been sufficient (2). Therefore, it is clear that this tool is not completely flawless either.

AI can also be utilised for direct management of patient conditions, such as recognising trends in symptoms and patient data and understanding if there is deterioration or improvement in these, and hence if this should be reviewed by a clinician. This AI tool could potentially be further enhanced by using self-testing techniques by patients, providing additional information. Another example of how useful AI could be in regard to recognising symptoms and signposting patients to the most appropriate services would be the use of AI in recognising and ruling out skin cancerous lesions from a photo taken from the patient's mobile phone. This could help to separate lesions which are not cancerous from those that should be investigated further and seen by the GP, and could improve the timeframe by which patients with skin cancer are seen by the GP and hence referred for management of same (2).

We all as human beings have an element of cognitive biases within us that are often very difficult to overcome. As healthcare professionals work with a range of people from all different walks of life it is very important that these biases, that may be present, are continually reflected upon in the hope that we can minimise these as much as possible. This could be another way in which AI could become a very useful part of GP practice. AI could be used to try to overcome these biases, through recognising trends in symptoms. The system may be able to recognise patients that are at more risk of serious health conditions, such as cancer, to try to catch these events at an early stage. However, this does come with a catch in that it would be important that the AI tool is developed using the relevant clinical information for the area in which it is being used, as one part of the world may differ in demographics compared to another (2). In addition, AI has been shown to uphold some of its own bias which can implicate its decisions, which can make it more susceptible to inaccuracies (3). Hence, one size may not fit all.

The rising cost of healthcare is an issue that is universal to both primary and secondary care, but often primary care providers can often feel more of an impact. It is very important to consider what methods could be implemented to try to reduce the cost to create more sustainable healthcare. It has been noted that between 2000 and 2015 the number of tests being ordered by GPs has risen over three-fold. This could be due to the ageing population and GPs consulting more patients presenting with chronic conditions as well as multi-morbidity. Hence, to try to reduce these costs as much as possible, whilst still ensuring that symptoms and conditions are not being missed out upon, AI could be used to support or challenge testing rationales within primary care (2).

There are many possible areas within General Practice where AI could prove to play a significant role and be of great value to clinicians. Following a workshop, a clinical problem which was thought to have potential AI input was the recognition of sepsis. This is a very important condition to identify at an early stage so that treatment can be initiated, due to the high mortality risk associated with it. Some patients with sepsis present firstly to primary care. AI could be used to identify early warning signs to depict those most at risk of sepsis and alert the clinician to also consider this as a possibility. This may then prompt the clinician to carry out further testing or to refer the patient to the emergency department. Patient safety and overall outcome could hence be improved. Another very relevant way in which AI could be utilised in primary care is for the management of type 2 diabetes. This condition has become more common and is often difficult to manage, due to the increasing number of medications that need to be prescribed to prevent further implications for the patient. AI could be used to suggest possible drug combinations according to the guidelines, so that the patient can avail of the most effective treatment (4).

There is also an ethical debate around the use of AI in General Practice. Some may argue that it could be an invasion of our privacy, if AI was to have access to our medical information, and that the autonomy to choose who has access to our data is breached. Some would also argue that there is a potential lack of autonomy with AI if there is a lack of understanding and confidentiality. Hence, appropriate and thorough communication with patients becomes a very significant part of this process. There is also concern regarding the use of surveillance activities to gather data, especially with regards to corporate involvement and possible financial gain. Some people may question who has access to this data and what would happen if there was to be a data leak or if cybersecurity issues were to occur. However, with respect to beneficence, AI could potentially aid in the protection and promotion of human health, through recognising trends at an earlier stage and perhaps improving overall outcomes for patients. In order to uphold ethical principles within General Practice it may be important to carry out regular audits on AI tools used, as it may be an unavoidable part of the future of healthcare (3). It is pertinent that we do not allow concerns regarding data ownership, access and issues regarding privacy lead to distrust between patients and the team in general practice, as this could be detrimental to patients’ care (4).

Whilst considering the impact AI could have on primary care it is very important to understand what the patient thinks of this evolving tool and how they feel that it will impact their care. A study was carried out to understand the patient perspective on AI in General Practice, specifically investigating their thoughts on the impact on the doctor-patient relationship, data sharing and implementation and use of AI in primary care. This study demonstrated that they felt they upheld a very strong doctor-patient relationship with their GP, with a high level of trust being shared. They also felt that the use of AI in General Practice was not detrimental to this relationship and felt that it was a useful resource to GPs. However, it was clear that patients felt it was important that the GP still maintained the position of being the primary decision maker (5).

In conclusion, it is believed that AI will have a broad impact on healthcare, including General Practice, and has prompted both excitement and concern. However, it is important to reiterate that although AI has the potential to be of significant benefit to patient care, it is imperative that it does not replace General Practitioners and other healthcare professionals but rather could be used to augment them. AI is expected to be involved in many areas of General Practice but particularly to support admin tasks and to aid clinical decision making. It is also important to consider concerns that patients may have regarding data protection. Therefore, it is clear that if AI could be used in a way that preserves the doctor-patient relationship, whilst providing support for clinicians, it may be of great benefit to patients and their overall health outcomes.

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Assessing Quality of Life in Parkinson’s Disease within General Practice in Rural Ireland

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Introduction: Chronic Disease Management in General Practice

Upon starting my General Practice (GP) rotation in August 2025, our professors and GP tutors emphasized the importance of Chronic Disease Management (CDM). The aim of the CDM program is to prevent and manage chronic diseases like diabetes, chronic obstructive pulmonary disease (COPD), asthma, and cardiovascular disease through structured, proactive, and continuous care provided by GPs. I was very impressed with this initiative and excited to begin working with CDM patients. I quickly learned that patient rapport is integral to the success of such a program, as demonstrated by various studies that describe positive patient-provider relationships as a key determinant in patient empowerment and personal disease management (Chiauzzi et al., 2016; Tan et al., 2021).

Patients on the CDM scheme often have multiple comorbidities, including a group of diseases of particular interest to the ageing population in Ireland: neurodegenerative conditions. Given the average age of onset of such conditions, it is common that many individuals with neurodegenerative conditions will have multiple health conditions and be on a variety of different medications, introducing another barrier to personal disease management termed “polypharmacy.” Therefore, it is pertinent that GPs work together with their CDM patients to continuously monitor and adjust treatment plans to best suit the individual.

From Research to Rural Practice: My Background and Perspective

I am currently mid-way through my 18-week GP rotation in the North-West of County Galway. Originally from Toronto, Canada, this practice has been a welcome yet major change of pace for me. I conducted my graduate research at the University of Toronto (UofT) in the largest mental health hospital in the country (Centre for Addiction and Mental Health – CAMH). There, I conducted neuroimaging research on patients with Parkinsonisms (PwP). The aim of my study was to identify an optimal neuroimaging biomarker to aid in the differential diagnosis of Parkinsonisms, as their prognosis and treatment protocol differ significantly from one condition to the next (Mena and Strafella, 2022; Mena et al., 2023).
Working in that environment changed my perspective on CDM and the importance of Quality of Life (QoL) assessments, primarily because many of our patients with atypical Parkinsonisms were initially misdiagnosed with Parkinson’s disease (PD) and experienced little-to-no benefit from typical PD medications despite having significant side effects that negatively impacted their QoL. Being in a major city, UofT had many resources available to monitor disease

progression and facilitate patient-centred care of such individuals. After working in a more rural environment for a few weeks, I could see that this level of resource availability and integrated care may not always be the case.

Patient Perspectives in General Practice

At my GP placement, I have had the opportunity to meet with each of our PwP and discuss at length what they feel is lacking from their care. Many of these patients initially came to see the GP because their increasing lack of independence impeded their ability to conduct activities of daily living (ADL). One patient in particular was struggling with the evolution of their role as a provider in their family. For years, their identity was tied to taking care of and supporting their partner and children, but since their PD diagnosis they have become increasingly dependent on their family. This type of role-reversal can be difficult to deal with, and such issues will often be discussed with an individual's GP, emphasizing that GPs are often the first and most consistent point of contact for PD patients, especially in rural Ireland where specialist services are limited.

Rural vs. Urban Practice: Key Differences

The differences between rural and urban practice are plenty, and having the opportunity to work extensively in both environments has taught me many lessons. Most importantly, it has highlighted areas of limitation and opportunities for improvement in rural PD management. PD management in rural practice differs from urban practice in terms of access to specialist care, travel and transportation barriers, the role of the GP, and patient experience and QoL.
In a rural setting, the average patient may live 2-3 hours away from the nearest specialist, thereby relying extensively on their GP for disease management (Cassidy et al., 2022). Additionally, although PD patients in rural areas may have a stronger sense of community and continuity of care with their GP, they can also experience higher degrees of social isolation due to the lack of PD support groups and the prevalence of stigma in smaller communities (Cassidy et al., 2024). Given the remote nature of rural practice, there are also barriers to medication management, technology and telemedicine, and palliative and supportive care. In local dispensing practices and smaller pharmacies in the North-West, there is limited stock of specialist PD medications which can cause prescription interruptions. Further, there is a digital divide in rural areas where elderly patients may lack confidence with technology for telehealth and phone check-ins with specialists. Finally, end-of-life care often occurs at home; although this is usually in line with patient preference, it can also place extraordinary pressure on family caregivers (Tan et al., 2021).

Quality of Life in Parkinson's Disease: Irish Context and Evidence

PD is the second most common neurodegenerative disease in Ireland, affecting 1-2:1000 of the general population and 1:100 of individuals over the age of 80 according to Parkinson's Ireland. Therefore, there are approximately 18,000 people living with PD in Ireland. Though broadly categorized as a movement disorder, many patients with PD often have non-motor manifestations long preceding their initial motor signs, which have significant implications for their QoL (Azizi et al., 2024).
On Thursday, April 2024 (World Parkinson's day), a research group from University College Cork (UCC) presented the first ever national audit of PD, encompassing both PD and the spectrum of Parkinsonisms (Azizi et al., 2024). Through this audit it was found that non-motor symptoms of PD are often under-recognized and under-managed in PD services, significantly contributing to suboptimal QoL. According to recent studies from an Irish perspective, longer disease duration, depression, non-motor symptom burden, mobility impairments, and perceived dependence are strongly negatively correlated with QoL (Cassidy et al., 2022). Upon further exploration, Irish individuals with PD ranked independence, autonomy, social connection, and ability to plan amongst the most important variables for improving their QoL (Cassidy et al., 2024). Overall, the literature supports the fact that QoL is a key issue in PD management in Ireland and there are deficits in care, especially around non-motor symptoms, psychological wellbeing, and community/support service access.

Proposed Clinical Audits and Practical Implementation

I am hoping to explore these burdens to PD care in two clinical audits assessing PD QoL and satisfaction with PD management at University Hospital Limerick and throughout the GP hub network in the North-West of Ireland. Though currently in the early phases of these projects, I hope to highlight the successes and pitfalls of PD management in both urban and rural environments and explore how GPs may be able to contribute to redefining success in chronic disease management.

I will be using the Parkinson's Disease Questionnaire (PDQ)-39 and structured interviews to promote patient-driven changes in PD management (Jenkinson et al., 1997). If used more routinely, such a QoL assessment tool has the capacity to empower patients, support shared decision-making, and guide resource allocation in rural areas. In practice this could be implemented with PDQ-39 (or the abridged PDQ-8) screening annually in chronic disease reviews in rural GP practice (Neff et al., 2018; Franchignoni et al., 2008). The results of such a pilot program would help track the efficacy of community engagement, PD nurse specialists, and palliative integration. Such a multi-disciplinary approach is essential to successful PD management, and it is integral to patient wellbeing that we consistently monitor the performance of such a care model.

If we recall the patient that struggled with the role-reversal brought on by their PD diagnosis, it is evident how such a framework might help alleviate this burden of disease. This patient is in the early stages of their diagnosis and is therefore a prime candidate for implementation of this approach. Given the rapport this patient has with the GP and surgery staff, they have expressed willingness to participate in such a survey on a regular basis. Through this process we may be able to identify barriers to care earlier and implement interventions such as physiotherapy or counselling to help this patient better adjust to their new role in the family. Though potentially seen as time-consuming, incorporating such a metric into the CDM review would be a significant step towards facilitating patient-centred care and improving QoL in rural PD patients.

Conclusion: Reframing Success in Chronic Disease Management

In conclusion, the assessment of QoL in PD offers a unique opportunity for GP in Ireland, particularly in rural settings, to redefine what "successful" CDM looks like. Rather than focusing solely on motor control or pharmacologic optimization, integrating QoL assessments acknowledges the complex interplay between physical, psychological, and social wellbeing that shapes each patient's lived experience. GPs are ideally positioned to lead this transformation because they provide continuous, patient-centred care that extends beyond the hospital walls. With the increasing prevalence of PD in Ireland's ageing population, adopting tools such as the PDQ-8 or PDQ-39 during routine CDM reviews could bridge the gap between clinical outcomes and meaningful daily function. Furthermore, incorporating such tools into practice would not only empower patients and promote shared decision-making but could also generate valuable data to guide national service planning under the Sláintecare framework. Ultimately, QoL should not be viewed as a secondary outcome, but as a vital sign in its own right – one that reflects the essence of GP: continuity, compassion, and community. By prioritizing this approach, we can ensure that every patient, regardless of geography, receives care that honours their autonomy, dignity, and individuality throughout their Parkinson's journey.

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Keep calm and wait for CAMHs – the challenges involved in the assessment and management of childhood autism and ADHD in primary care

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Introduction

It is often said that school days are the best days of our lives, when we can enjoy being carefree and unencumbered by life's tribulations. However, for some children this is not the case. This period in life can be particularly stressful for those with neurodiversity - including autism spectrum disorders (ASD) and attention deficit hyperactivity disorder (ADHD) - and indeed, for their parents. Turning initially to autism, while the diagnostic criteria includes signs that present in the early developmental period, it is often when children are placed in an unfamiliar environment, such as a classroom, that challenges can arise. The average age of diagnosis is 60 months (5 years old)[1], the age at which most children will have started school. Similarly, ADHD symptoms can become more obvious in a school environment when there is a requirement to deeply focus and complete tasks in an organised fashion. It goes without saying that children and young people with these diagnoses require additional support. However in order to obtain this support, there needs to be timely recognition, diagnosis and treatment of the condition. This is where the health system lets people down. The pathways to access the appropriate services can be confusing and convoluted, there are significant wait times, and from a governance perspective, it is unclear who is primarily responsible for managing these patients. As the gatekeeper of the health service, the General Practitioner is often the one caught in the crossfire. The majority of patients will first present to their GP, who does not have official jurisdiction to diagnose these conditions. When a referral is made to the service, there is often a delay of several months. This can lead to a feeling of hopelessness for the practitioner, along with parental frustrations. Even after diagnosis and assessment by psychological services, issues can arise with the accessing of services and prescribed medications, again leaving the GP caught in limbo.

Notwithstanding the systemic issues, many GPs feel that these conditions lie outside the area of their expertise. Additionally, we are living in a digital age where information and misinformation are available at the click of a button and this can add an additional layer of difficulty for medical practitioners.

Hence, in this essay I will explore the implications of these issues on general practice today, and discuss future directions.

Current statistics

While there is no official register for data, it is estimated that autism effects 3.38% of schoolchildren in Ireland[2] and the prevalence has been increasing over the past number of years. Similarly, it is difficult to obtain precise data on ADHD but there is an estimated prevalence of 1-3%[3]. There is often overlap between the two disorders. Recent Irish data demonstrates approximately 21% of patients with an ADHD diagnosis also have diagnosed ASD, however the actual overlap rate is probably higher as there is likely a significant cohort that remain undiagnosed[4]. In practical terms, most GPs will have several children on their books with these conditions.

Diagnostic challenges

Turning initially to the diagnosis of autism, the diagnostic pathway can be a minefield for parents and clinicians alike. The HSE webpage on "how to get assessed for autism" provides a list of professionals you can talk to, the first one listed is the General Practitioner[5]. It is clear to see why patients are frustrated that their GP cannot make the diagnosis. The correct route to take for assessment for public patients is via either an assessment-of-need or a CDNT (children's disability network team) referral. The assessment of need form is submitted by the child's caregiver to the local HSE assessment officer whereas a CDNT referral can be completed by a caregiver or health professional. The Disability Act of 2005 outlines a target, for all assessments of need to be carried out within 6 months[6]. However, figures from the HSE suggest 90% of children are not seem within this timeframe, and they estimate that 25,000 children will be awaiting an assessment of need by the end of 2025[7]. It comes as no surprise that those with the means to pay may seek a private assessment – which carries a much shorter waiting time but can cost somewhere between €1000-2000[8]. The disparity between public and private patients and access to care is evident throughout all factions of the healthcare system; however it is particularly difficult to process this staunch inequity when it relates to small children being unable to access the care they deserve. As doctors, we take an oath to provide the best care possible to all our patients but the system simply does not allow for this, and this can lead to feelings of hopelessness and guilt for GPs.

Regarding ADHD, the diagnosis here is generally made by a psychiatrist or chartered psychologist as part of the child and adolescent mental health service (CAMHs). The pathway here is slightly clearer than with autism – typically following presentation to the GP, a referral can be made directly. Again, delays remain an issue with this pathway, but in addition to this there are ongoing concerns from the healthcare community and the public in general about the functionality of the service. The Maskey report was a review conducted of the South Kerry CAMHS service in 2022, based on concerns that had been raised by clinicians. This review identified 240 children whose care did not meet the necessary standard; some were given the wrong diagnosis, some given inappropriate medications, and some children had inadequate follow up and monitoring of their treatment[9]. This has understandably caused a lot of fear and panic for parents. Additionally, a survey carried out on a cohort of Irish psychiatrists, found that 65.7% of psychiatrists reported a decline in their motivation following the publication of this report, and that 62.7% feel their workload is unmanageable[10]. It is a vicious circle of sorts; pressure on the system leads to deficiencies in care, which in turn lowers motivation. While everyone involved is trying their best, it is ultimately the children and their families who suffer and there are no signs of any reform to the service.

Consequences of a delayed diagnosis

The timely diagnosis of Autism and ADHD, and prompt intervention, are vital to improving the trajectory of the conditions. It has been shown that early diagnosis of autism can improve cognitive function, speech and social behaviour in children, due to evidence-based interventions, particularly if they are diagnosed before the age of two and a half[11]. Interestingly, the American Association of Paediatrics recommends screening children for autism at their routine 18 and 24 month paediatric led reviews[12]. For ADHD, there are several studies demonstrating short to medium term gains in terms of academic performance in children who are diagnosed and treated in a timely way[13]. There is a paucity of evidence demonstrating long term gains and this remain a contentious issue[14]. However we know that of patients that seek help for mental health conditions in adulthood, a large proportion have undiagnosed or untreated ADHD. This has been reported in up to 20% of patients in US data[15]. There is also a large body of evidence suggesting that patients with substance abuse disorders have higher rates of undiagnosed ADHD than the general population, again up to 20%[16]. A strong link between late diagnosis of autism and substance abuse has not been demonstrated however in patients diagnosed with autism during their adult years, there are high rates of unemployment (up to 50%) and co-existing anxiety/depressive disorders[17]. From this data, we can infer that by recognising and supporting these conditions early in young people, it may be possible to mitigate or minimise these issues.

MDT and support services

Many children who have obtained their diagnoses of autism or ADHD will benefit from multidisciplinary team involvement, such as speech therapy and occupational therapy. There is no official data on waiting list times however anecdotally we know many children wait months or even years to see these community specialists. Regarding additional support in school, special schools naturally have a limited capacity, and cannot always offer a place to those who need it. In mainstream education, special needs assistants are allocated to the school itself rather than individual children – hence, there is no guarantee that a child who would benefit from this additional support, will receive it. As an individual health care professional, there is very little that can be done to change this, which again can be a source of frustration and hopelessness when a family comes seeking help. Again, under-resourcing and deficiencies in the social system, leaves these children at a disadvantage in terms of their development and education.

GP reported confidence

The General Practitioner will generally care for these patients as their primary physician, and as previously mentioned, a GP can expect to have several patients with these diagnoses on their patient lists.

Interestingly, a UK based study that surveyed 304 practicing GPs on their confidence in caring for patients with autism, reported a mean self-rated confidence score of 4.8 out of 10[18]. Additionally, 63.5% of the participants reported not receiving any formal autism training during their undergraduate or postgraduate training. In relation to ADHD, an Australian study found that 70% of GPs feel they lack the knowledge and experience to manage a child with ADHD[19]. I feel that this highlights again the systemic issues which contribute to poorer outcomes for these patients. Modern GPs have an extremely busy caseload and limited consultation times. This, coupled with a lack of focused training and limited support from very stretched secondary care services, leads to a perfect storm. It is not in the least bit surprising that GPs rate their confidence as "low" when it comes to looking after these patients. To combat this, it is imperative to provide structured training opportunities for GPs, trainees and students. Additionally, broadening access to secondary care services and improving the chains of communication would go a long way towards helping this problem.

Medications

ADHD is commonly treated with stimulant medications such as methylphenidate and lisdexamphetamine, which are often highly effective. These medications must be initiated by a consultant psychiatrist or ADHD specialist. Given the high number of children with ADHD in Ireland today, the CAMHS service is of course, severely stretched. Hence, a common occurrence is that once a patient is stabilised on the medication, the GP is asked to take over the responsibility of repeat prescribing. This raises a number of issues. Firstly, these medications require frequent monitoring. Blood pressure and heart rate require monitoring every 6 months, or after a dose change. Height must be monitored every 6 months, and weight must be monitored every 3 months for children under 10, and 6 months for children older than 10[20]. This regular measurement in and of itself is a significant clinical commitment. There are also several described adverse effects from these medications, including tachycardia, arrhythmias and even sudden cardiac death[21]. This raises a question of responsibility – is this under the jurisdiction of the initiating physician or the primary physician? It is likely that the liability will fall to the doctor who wrote the most recent prescription. On the flip side, if the GP declines to sign the repeat prescription and the patient suffers clinically as a result, again the GP will likely be considered to be at fault. It is a very difficult position to be in. The positive news is that there is additional training available for those that want it - there is a two-day UK based training that enables GPs to become competent in diagnosing ADHD and prescribing for patients[22]. Additionally the ICGP is in the process of developing online training for GPs on the subject of ADHD management and prescribing, and it is felt that the uptake for this training will be high.

The transition period

Another challenge in the care of these patients is providing the due care and support as they reach adulthood. For young people that have been linked with and are attending the appropriate child and adolescent services, an additional stressor comes in the form of their care being shifted from the child and adolescent services to the adult services. This transition does not always occur smoothly. A study of Irish adolescents in 2015 showed that of a cohort of sixty-two CAMHS service users, forty-seven (76%) were identified by their clinician as having ongoing health needs as they approached the transition period[23]. Only fifteen of these patients were referred to adult services; twelve patients continued to attend the CAMHS service beyond age eighteen. Of the forty-seven patients, sixteen of these patients had an ADHD diagnosis but only one of them was successfully transferred to the adult services. ADHD was identified as the condition least likely to be referred onwards, either due to clinician factors (of note, the clinicians frequently remarked that they didn't believe the adult service would be able to meet the needs of the patient), or patient refusal. The results of this study are concerning. It highlights the lack of a clear protocol or streamlined approach for the transfer of these patients' care, at a time in their lives when they are very vulnerable. The fact that many patients are kept on by the CAMHs service beyond their eighteenth birthday demonstrates the dedication of individual clinicians to their patients. However, the system cannot be reliant on this to ensure continuity of care. Instead, a clear pathway should be put in place, such as the development of dedicated transition teams. Similarly for children with autism who receive multidisciplinary care through the CDNT, ideally a transition to adult disability services should occur after their eighteenth birthday. Frequently, however, patients with mild-moderate autism can be left without ongoing support. Often the patients' family and GP are left to co-ordinate care in the absence of structured follow up. Overall, this demonstrates yet another gap in the system where patients can be abandoned, and highlights the need for reform.

Misinformation

An ongoing challenge that all healthcare providers face is contending with misinformation, and misinformation surrounding ASD is common. One of the most famous examples of this is a paper published in the Lancet by Dr Andrew Wakefield in 1998, suggesting a link between the MMR vaccine and autism[24]. This study has of course been widely discredited and redacted, however the fallout from this publication was huge. Naturally, vaccine rates fell following publication of the study. In the year 2000, the vaccination uptake rate in the North Dublin catchment was less than 70%, and there was a resultant measles outbreak which saw 111 children hospitalised and 3 children die[25]. In addition to the catastrophic effects of vaccine hesitancy, this publication also created stigma about autism itself, framing it as a side effect rather than a complex neurodevelopmental diagnosis. In modern times, we have observed the most powerful government in the world make outlandish statements about maternal consumption of paracetamol leading to autism. The media is a very powerful tool and as such, fear is rampant at the minute. Following announcements like this, patients are caregivers can be left feeling concerned, confused and guilty, and this is on top of the stress they already experience trying to navigate the health service. It takes a particular skillset as a doctor to ensure the patient feels their concerns are being heard, while steering them towards the correct resources.

Going forward

Taking into account all the above, it is important to focus on what can be done to help manage these issues.

As an individual GP, it is important to get the basics right. This begins with listening to the patients' concerns and providing an empathetic approach. It is important to be aware of the referral pathways and secondary care support available – and be mindful of potential alternatives, such as private services or charities which can provide support to patients and families. Additionally, helping to manage symptoms such as sleep disturbance and constipation can go a long way to making the patients' journey a bit easier. On a wider level, standardised training for General Practitioners and trainees would be invaluable in empowering GPs to support these complex patients. From a systemic standpoint – it may be worth considering a screening pathway similar to the US model, to ensure that symptomatic children are diagnosed and supported as early as possible. A barrier to this is the shortage of community paediatricians – unlike the US model, most Irish children do not routinely attend a paediatrician. However the creation of a neurodevelopmental review programme by public health, or even a school screening programme could be an innovative way to flag children for review at an early stage. It goes without saying that increased funding is needed to improve access to services and create new pathways - there are several groups lobbying for this in Ireland currently and it is hoped that the government will take this on board.

Conclusion

Evidently, the challenges of assessing and managing autism and ADHD in the community are manifold. The optimum care of these children requires a well-functioning system to support early diagnosis, resource provision and ongoing care beyond childhood, while supporting and empowering clinicians to develop their knowledge and best support patients and families. Ultimately, we are and always have been a neurodiverse society. While the current system has multiple failings, we have come a long way in the past fifty years – when patients with these conditions would have been branded "difficult" and punished just for being themselves. The key for us as doctors is to keep having these conversations, learning, and advocating for the rights of these patients; hopefully with time, we will see reform to the system within our working careers.

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The Waiting Room

Author: Ciara-Jayne Thornton, Undergraduate, QUB, 5th Year Medical Student

As the car door locks behind me, I head through the waiting room to my office to start the day. The waiting room hums with quiet talk, phones ringing, and the odd cough. The receptionist nods a hello, already juggling calls and appointments. I get to my desk and check the list, ten patients waiting. Ten people, each with their own reason for being here.

8:45 AM – Mrs. Donnelly

She is always early. Seventy-eight, widowed and fiercely independent. Her knuckles grip her handbag, a shopping list sticking out. She is here for a blood pressure check, but she will ask about her neighbour's shingles, her grandson's eczema, and if cod liver oil really works miracles.

"I've been coming here since my husband passed. You're the only one who remembers his name," she says to me.

She reminds me that general practice is about more than medicine. It is about memory and being known. The morning moves on and yet I allow her words to linger in the back of my mind.

Dr Denis O'Donovan, who left city life for rural practice in West Cork, described the joy of knowing his patients deeply, *"You're not just treating a person—you're part of their story. You know their family, their farm, their fears."* (Irishcollegeofgps.ie, 2025)

9:10 AM – Connor

Fourteen, hoodie up, headphones in. He avoids eye contact with the receptionist, but nods when called. His mum booked the appointment because she is worried about his sleep and his mood. I am surprised he decided to show up.

He slouches in the chair. I ask about school and friends. He shrugs. I ask about home. Another shrug. Then, I ask about sleep.

"I just feel... tired. All the time. Like I'm not really here," he responds quietly.

I am reminded of how hard it is to be 14. We talk about anxiety, about pressure, about how it's okay not to be okay.

He leaves slightly lighter than when he came in. I hope I got through to him and he knows to come back to talk to me should things get worse. I make a quick note to check in with him in a few weeks.

Ireland has one of the highest rates of teen suicide in the EU. A 2024 report found that 22% of 15–19-year-olds in Ireland had a mental disorder, with anxiety and depression accounting for 63% of cases. (Staff, 2024)

A survey of Irish GP registrars found that 91.7% felt they needed more training in child and adolescent mental health. (Reilly, Doherty and Cullen, 2024)

9:30 AM – Mr. and Mrs. Patel

Married for fifty years, they never come alone - Mrs. Patel doesn't trust her husband will tell me fully what's going nor will he take her worries seriously until he hears it from me. Today is a medication review for Mr Patel, but they will ask about flu jabs, their daughter's pregnancy, and my weekend plans.

"You're part of our family now," Mrs. Patel says, smiling. "We trust you."

Their trust has grown over years of shared decisions and quiet reassurance.

Dr Brendan Gilmartin, a GP in the Midlands said, *"You become woven into the fabric of the community. You're not just a doctor—you're a neighbour, a confidant, a witness to life's milestones."* (Irishcollegeofgps.ie, 2025)

10:00 AM – A New Face

She is nervous. Her eyes move around the room, fingers tight on her bag. She is new to the area and to the practice. Her form says fatigue, but her posture says fear. She whispers that she has not felt right in months, but did not want to bother anyone.

We talk. Her story comes out: work stress, insomnia, a recent breakup. I remember how isolating it can be integrating into a new community with no support. We discuss community life here and the countless groups she can join, I reassure her that we are welcoming in this town. She leaves with a plan, a follow-up booked and a slight smile on her face.

10:30 AM – The GP's Moment

I step out to call the next patient. I scan the room, looking for names, for faces tired or worried, for tense shoulders and quiet stories.

This room holds more than patients. It holds people waiting for news, for relief, for hope. With each visit, the stories accumulate, woven into the fabric of the waiting room.

10:40 AM – The Child with the Dinosaur

He is five, holding a green and purple plastic triceratops and bouncing on the seat. His mum looks tired. She is here for reassurance: a cough that will not go away, a rash that might be nothing.

He growls loudly at me, holding the dinosaur up for me to inspect. He has been roaring like that all morning, his mum says, smiling. The laughter is a brief pause before the next concern arises.

11:15 AM – The Man with the Envelope

He holds a sealed hospital envelope. He asks me to read it first. His hands tremble. "I just… I don't want to read it alone."

Inside is a diagnosis. It is not unexpected, but it still carries the weight of grief. We talk through the next steps. He nods. He leaves with some questions answered, but at least now he has someone to go through this journey with.

Dr Meera Kugadas, said, *"One moment you're treating a toddler with a cough, the next you're supporting someone through grief. It's the most human form of medicine."* (Irishcollegeofgps.ie, 2025)

12:00 PM – The Carer
She is not here for herself. She is here for her mother, who sits beside her in a wheelchair, eyes closed. The daughter looks tired.
"I'm just trying to keep her comfortable. But I'm so tired. I feel guilty even saying that."
We discuss supports, respite, and community teams. I tell her she is doing enough and book her a full carers review with our practice nurse who can offer more time than I will ever be able to. As the morning list ends I finally take a moment to breathe.

12:30 PM – Lunchtime
The last patient leaves. The waiting room door closes as the room empties. The receptionist exhales and locks the door. I eat my sandwich at my desk while filling out more prescription requests and check the afternoon list. It is already full. More names. More stories. More waiting.
Outside, the waiting room is quiet. But it will not stay that way for long. There are always new stories to fill these seats.
As Dr Anthony Cummins, an Irish GP, once said:
"It's very humbling being a GP… The people you meet are actually teaching you personal things."
(Mindo, 2024)
In the waiting room, the personal connection is clear. It is where the GP's day begins and the patient's story starts.

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Happy Father's Day: A Façade of Celebration masking Paternal Postnatal Depression

Author: Debasmita Sanyal, Undergraduate

Introduction

It was my usual morning, waking up in my languid haze to grab the first cup of coffee and rushing through my shining screen to get a glimpse of the work piling up in the notes section. I was half way through my work when suddenly a couple of notifications made their way in, vexing my morning clumsiness. I picked it up and checked the first pop up, it read "It's not too late yet!", below it, were a list of options to gift your dad on Father's Day. Before my mind could actually settle on buying gifts, I clumsily glanced through my socials.

The first post that came right through was a childhood picture of one of my school friend's, alongside, what seemed ostensibly, her father, in a playground. A long monologue followed it, and as usual considering it a quixotic waste of time, I scrolled past. But something struck me at the moment, remembering, how at school, a subtle talk surrounding her father crept into the classes. I started reading the post. It was a few minutes read.

A thought surfaced in my mind. Her father had committed suicide when she was four and as she put it there, he had suffered from severe depression. Things had started to take a toll as she grew up, and all ended with her family rummaging through his memories without having any reason to justify his absence.

Now, the important question that arises, whether he was the tip of the iceberg which held in itself a fulminating cause that new fathers grapple with. I would thereby like to introduce a not so common term witnessed or rather acknowledged by us daily; Paternal Postnatal Depression (PPND). PPND is not only an abandoned mental health scenario among men, but a highly arcane and underdiagnosed condition by the medical practitioners. The massive load of emotional transformation that an individual has to go through while entering their phase of parenthood, clutches not only new mothers but the fathers as well. "Postpartum depression" or "Postnatal depression" does not befog us anymore. The rosy idealism of gratefulness meant to feel after welcoming a new life to the world is often rather filled with severe distress and depressive, anxious, clouded thoughts for many women. As I must repeat, this entire scenario is best associated with mothers, but not with fathers, and most people might not even be acquainted with the "Paternal" adjunct to this very particular topic. While this tumultuous and pernicious feeling often plagues women, a very big part of it also involves the new fathers. According to a study by Philpott et al., about 12 % of the Irish fathers who had experienced recent births, qualified on the Edinburgh Postnatal Depression Scale for PPND (1). When the cut off score was lowered to include minor depressive symptoms as well, the prevalence increased to 28%(1). But the more pertinent question that is yet to be asked is: How is PPND assessed by healthcare professionals? Is the GP practice looking behind the fence to underline the mental conditions of new fathers? If not, then does it jeopardise the life of a man and his family?

Understanding Postpartum Depression in Men

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Peripartum depression is defined as “Major depressive episodes occurring during pregnancy or within 4 weeks following delivery.” However it can often pursue an insidious course and appear within 3-6 months or even a year postpartum (2). The Edinburgh Postnatal Depression Scale (EPDS) for determining postpartum depression in women, was used to validate the cut off score for men; it showed lower scaling as compared to women, indicative of only minor depressive states. This was thought to be because, men are often considered to be inarticulate about their feelings as compared to women, so the levels of study outcomes often cast an undermined value to the severity of their depressive states (3). During and after the birth of a child, the father undergoes hormonal changes as well which is thought to influence or heighten the strong father-child bond (2). According to a study by Kim and Swain, increased oestrogen and decreased testosterone levels in a father is associated with an enriched paternal affection (3). Other hormones attributed to a more gratifying parent-infant bonding include vasopressin, cortisol and prolactin. The levels of hormone are shown as a contributing factor in development of PPD in men, for example, decreased testosterone is associated with depressive states in men, whereas decreased oestrogen , prolactin, vasopressin contribute to a difficulty in bonding with the child(2).

According to a study in Maynooth University, National College of Ireland, and Trinity College Dublin , 42% of Irish adults qualify for at least one mental health distress(4). According to reports, the most prevalent predictor of PPND is maternal postnatal depression with about 2.5 times greater predisposition than those whose partners revealed no history of PND at six weeks postpartum (1). Other contributory factors include previous history of psychological distress especially depression which may resurface or exacerbate during the perinatal period ,initial challenges faced during childcare exceeding expectations, unplanned pregnancy, low educational qualification of the father(1). All of these changes culminate into a major stressor for predisposed men as well as those who previously did not report any psychiatric distress.

Impediments Faced in the Diagnosis of PPND

As far is PPND less talked about, evidences from self-structured interviews and quantification of reports suggest that it is a real and grave entity. Yet no Diagnostic Criteria or set of rules have been designed for a structured approach towards it. A major trouble faced by most primary practitioners is the lack of knowledge regarding the delayed nature of onset of PPND as compared to maternal PPD which is thought to take its toll within one month postpartum(3). General Practice acts like a filter in the detection, assessment and treatment of mental health problems. Although according to reports, 25% of the patients visiting the GP reported on having psychiatric issues and 95% of them were managed in the primary care, the burden of depressive states have been on a rise since 2020 and has achieved a second position on the WHO list of global health issues just after coronary artery disease(5).Research in other countries indicate that as much as half of the patients presenting with depression continue to remain undiagnosed on their first consultation and eventually 18% of them continue to remain so and the rest are either supposed to get better or be detected later(5).

Ireland has very little research showing the fragility of diagnosing depression especially in men. PPND remains even more an obscure diagnosis considering the lack of evidence regarding its existence and the social stigma surrounding young fathers, expected to be taking responsibility of the household especially during the postnatal period. Practicing routine feedback through simple questionnaires do not prove to be of any great significance especially in paternal depressive states when the diagnosis itself remains clouded(5). Ireland faces a shortage of mental health competence and has specificities in lacking proper diagnosis and treatment of mental health issues. Most Irish GP lack the knowledge and dexterity in handling the wide array of psychological symptoms, which pushes mental health among men to an even darker corner(5). There is lack of shared knowledge between psychiatrists and GPs due to difference in hospital based and general psychiatry practices, which accentuates the delay or failure to manage psychiatric complaints. Lack of information such as voluntary agencies and self-help groups among the GPs also play a role(5).

Health economics does play a part in influencing the overall mental health of Ireland. Especially so, the application of direct cash payment for GP funding by the majority of patients is unlikely in an European setting(6). Previously, all Irish residents were allowed free public health facilities and prescription medicines provided their income was below a specific threshold or were in a certain age category. Research showed that this had impact on the utilisation of health services and not on health outcome (6). However, after 2015 new regulations made GP service free to all aged under 6 and over 70, no matter their incomes. It is very simple to relate that health insurance policies alleviate financial distress of the population and thus participate in reducing stress overall(6). According to the reports so far financial distress play a significant role in PPND, and can be used as a diagnostic-criteria in the future.

The need for extensive research on paternal depression especially in the Irish population stems from the factor that about 19.7% prevalence of maternal PPD has been found from a study by Cronin,2012. Since maternal depression is a strong causal factor for PPND, the prevalence rate may reach the same(1).

Impact on overall family health and role in infantile depression

Family dynamics including the upbringing of the child is mostly affected due to the fragile mental status of either parent. Like major depressive states, PPND is also described as a conglomeration of symptoms like apathy, fatigue, anxiety, guilt, increased suicidal thoughts; all of which impair the ability to meet basic household responsibilities and dispute with their partner(1). As mentioned previously, PPND is more common in men whose partners suffer from postpartum depression, which indicates that PPND may have a causal role in aggravating maternal depression. Inability to meet fatherly responsibilities and lack of sensitivity, bonding and warmth towards the newborn affect the child's wellbeing(1). Children with depressed fathers have shown symptoms of conduct disorders, hyperactivity and emotional anguish (1).

According to Lamb and colleagues, three components of children's behaviour ,namely, interaction, availability and responsibility are attributed to father's involvement(7). Less involvement of the father indicates the child might need to work harder to get the attention and bonding from the father which is directly proportional to a rise in oppositional behaviour (7). According to a study by Ramchandani et al. changes in the key aspects of father-infant interactions result in early onset behavioural changes in the child(7). Decreased bonding between father and child may also reflect wider conflicts in the family , especially in the father and any behavioural disturbances like antisocial traits may directly manifest in the infant(7). According to a cross-sectional study , more the depressive symptoms in the father, stronger is the relation between mother and child's symptoms(8).

Need for GP training and Social Awakening

A simple example that I can put through from an open perspective is that when a husband gets concerned about the depressive manifestations of his wife and how it may impact the child, he considers his emotions as rather unnecessary and "un-manly" at such a crucial point in his life. He holds this view in-front of the GP to whom his sole concern is his family, and this very family forgets to include him because fathers are assumed to play the role of the roots which hold the plantlet, the family. This universal perspective about watering the plant and letting the roots rot, just by assuming they are "meant to be strong" needs to change. GP practice acts as a primary care and this adds to the benefit as to how it may act as a solution to the stigma that men face regarding their mental conditions.

WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Postpartum depression is a serious yet treatable condition. In young fathers, the need for them to acknowledge PPD as a mental health condition is the first challenge to be faced. Most men, especially after birth of their first child realise a shift of duties from individuality to a family unit. Social groups and online forums recognising PPND and normalising the "disgrace" among first time fathers can be a considerable approach.

Acceptance from the medical professional, like GPs will be a big step towards helping men seek medical attention. Reports suggest that infants of fathers with depression suffer from agitation and decreased sensitivity which heavily impacts their character development(2). To improve overall childcare and family wellbeing, the GP practice needs to focus on the mental health of men as well. Training of the GPs like workshops and webinars emphasising on couple screening after childbirth and including basic questionnaire-based surveys as a part of routine checkup can improve the outcome. Financial stability and education play much role in PPND. Focus can be put forward towards socio-economically hindered families through health camps and social awareness campaigns.

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That’s Unfortunate: Diversity-Conscious General Practice in Ireland

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I recently attended a clinical workshop facilitated by a general practitioner (GP) where the GP demonstrated a procedure on a simulated patient. A part of this demonstration relied on the blanching of the patient’s skin where blood flow was temporarily occluded by applying pressure, i.e., relying on the quick window of discoloration on the patient’s skin before capillary refill quickly set in. Almost immediately, I realized that this part of the procedure might not work as expected for me if I were the patient. As a Black woman with melanin-rich skin, the capillary refill test is less accurate and can only be confidently relied on in certain parts of my body, such as my palms, soles, and tongue.

What followed next was an interaction that would send me into deep thought for the next couple days. I mentioned to the GP that this part of the procedure may present a problem for patients who look like me—patients with darker skin tone. Their response: “Oh, well that’s unfortunate.”

What I thought might be a great learning opportunity for me and the other workshop attendees—a moment to learn about the nuances of providing patient-centred care where patients don’t all look the same—turned out to be a slightly uncomfortable moment. We swiftly moved on with the rest of the demonstration, but somehow this interaction lingered in my mind for the rest of the day. For a sanity check, I spoke with a few trusted friends, also medical students, who were empathic and understanding of the situation. It would be another 24 hours before my brain could finally consolidate my thoughts. As a dark-skinned woman living in Ireland, I wasn’t quite sure that I had enough faith in a GP to help me if I presented with symptoms different from my White counterparts.

It goes without saying that the role of a GP is critical to the health of individuals. In Ireland, and any other country with a properly functioning healthcare system, GPs are the first port of call for any health concerns. Before a referral can be made to a specialist, a GP is usually the one who does the first assessment to determine whether a health concern needs to be escalated. In a sense, GPs serve as gatekeepers in the healthcare system, they grant access to more specialized care and can serve as advocates for patients in getting the treatment they need from specialists. But as the saying goes, to whom much is given, much is expected. As prestigious in some sense as the role of a GP might be in society, it also requires a lot from whoever decides to accept this title. Consequently, a missed, delayed, or dismissed diagnosis from a GP can potentially be detrimental to the health of a patient.

As a Black woman and as a medical student, my lived experiences have fortunately (and unfortunately) exposed me to the nuances of presenting complaints that may arise from patients of different backgrounds, racial identities, and skin pigmentation. I am fully aware of racial disparities in healthcare, and the fact that sometimes a missed diagnosis, especially in patients with dark pigmented skin, has some correlation to a higher mortality rate. For instance, in the case of melanoma, studies have shown that while White patients have the highest incidence of the disease, non-White patients — especially Black patients — have the highest mortality relative to incidence.[1] This discrepancy is attributed to a number of factors, including atypical presentation and significantly less clinical training in diagnosing melanocytic lesions in patients with skin of colour.[2]

Bringing it closer to home, in a recent Ireland-based study on the accuracy and confidence in diagnosing skin diseases in darkly pigmented skin, Irish GPs were shown to have lower confidence levels and accuracy in diagnosing common skin conditions in patients with darkly pigmented skin.[3] The three major attributable causes were: inadequate education during medical training, shortage of educational resources, and inadequate exposure due to the Irish population predominantly having light skin pigmentation. Objectively speaking, the last of these points is valid. According to the 2022 population census, about 86% of individuals identified as White Irish, White Irish Traveller, or any other White background [4]. However, the results of this same population census also showed an upward trend in the population of people of color. Since the last population census in 2016, there has been a 17% increase in the number of people who identified as Black or Black Irish, and a 38% increase in the number of people who identified as Asian, or Asian Irish. It goes without saying that GPs can expect to have more exposure to patients with an array of skin pigmentation in the near future. As such, it is pertinent that Irish GPs are adequately prepared to cater to this population.

So what then can be done? How can Irish GPs be better equipped in catering to patients of diverse backgrounds, ethnicities, and skin colors? In my opinion, the answer lies in a multi-layered, all-hands-on-deck approach starting right from the beginning — medical school.

As we know, there are a lot of systemic diseases that present their first signs on the skin. [5] For example, infections like cellulitis, xanthomas in the case of dyslipidemias (and subsequently cardiovascular disease), and jaundice in the case of liver disease all have skin manifestations that often warrant a visit to the GP. Medical training relies heavily on visual learning aids to teach students about these dermatological presentations of diseases. Studies have however shown that currently, there is an underrepresentation of dark skin tones in dermatological texts and medical image repositories. [6] The consequence of this is that medical students graduate and become physicians with a narrow view of dermatological presentations of certain diseases and limited ability to correctly diagnose these conditions in patients of varying skin tones.

To address this problem, there needs to be increased awareness of the need for diversity in medical training amongst all parties involved in medical education, i.e. students, lecturers, and faculty. As future physicians, students need to be more curious in learning and asking questions like “how does this symptom present on individuals with darker skin than illustrated in this image?” or “are there are racial disparities in the presentation of the symptoms of this condition?” Questions like these bring diversity into the consciousness of everyone, lecturers especially, who hopefully take this into account in subsequent teaching. In preparing teaching materials, notes, and lecture slides, it is important that lecturers include more diverse materials and dive a little deeper into atypical presentations of diseases. During faculty meetings for reviewing the curriculum, there should be a metric for assessing diversity and inclusion in classroom and clinical teachings.

The collaborative effort between students and lecturers can even go a step further as seen in a recent project at the Hackensack Meridian School of Medicine in the United States where students, librarians and faculty joined forces to address the shortage of pathology images of diverse skin tones.[7] In this project, the students, empowered by the faculty and librarians, created a database of diverse images of skin pathologies. The database was then distributed to course directors and lecturers who used some of these images in creating teaching materials for the next cohort of students. This kind of initiative bestows a sense of duty to both students and lecturers in ensuring that the GPs of tomorrow are adequately prepared to cater to a diverse set of patients. Irish medical schools can adopt and incentivize initiatives like this to encourage more students and lecturers to be all-hands-on-deck in improving diversity in medical training in Ireland.

When we become more intentional about encouraging diversity in medical training today, the results are evident in the quality of care and competence in the GPs of tomorrow. This was demonstrated in a study at the University of Hamburg (Germany) where fourth year medical students (in a six-year program) attended mandatory skin-type diversity seminars. [8] The results of the students’ self-assessment indicated an increase in the knowledge of skin presentations of diseases in patients with skin of colour, as well as an increase in the ability to diagnose these diseases.

The next layer of equipping general practitioners, and healthcare workers in general, with skills to cater to a diverse population lies in intentionality after medical school. The field of medicine is an ever evolving one that requires a commitment to continuous learning. Physicians must intentionally engage in practices that keep their knowledge and skills up to date to provide the best care for patients. To be better equipped to serve the growing diverse population of Ireland, it is pertinent that GPs take steps to close their knowledge gaps on the nuances of symptom presentation and disease manifestation in patients of different ethnicities and skin pigmentation. In the aforementioned Ireland-based study on the accuracy and confidence in diagnosing skin diseases in darkly pigmented skin, about 89% of the participants indicated that they would have liked further training on dermatology in darkly pigmented skin. The awareness of their knowledge gap should be an opportunity to partake in self-directed learning, group training, seminars, workshops and conferences targeted towards addressing diversity in medicine.

In addition, it is important that GPs adopt the use of standardized diagnostic methods and tools where possible. For example, a study showed that regardless of skin color, the use of visible and near-infrared spectroscopy was a more effective tool used for the early detection of pressure ulcers. [9] This study was carried out after it was observed that the blanch test was difficult to assess in patients with highly pigmented skin in contrast with patients who had lighter skin. Based on this observation, there was also a resultant amendment in 1998 by the North America based National Pressure Ulcer Advisory Panel in the definition of Stage 1 pressure ulcer to reflect this difficulty. Upstream acknowledgements by unions and organizations like this are a positive signal downstream to individual GPs to become more conscious of diversity in medicine. These GPs in turn will also play a part in training the next generation of diversity-conscious GPs who go on to provide a safe space in Ireland where patients of all skin types and ethnicities can be served.

For the past year and half, Ireland has been my home away from home and has provided me with quality medical training. In this short while, I've had encounters with many incredible GPs both in the learning environment and when I've needed medical attention. As great as it has been, there's always room for improvement. By implementing intentional practices, starting from medical schools and beyond, Ireland can become a country that has (and produces) well-rounded diversity-conscious GPs. I believe that with the right call, it can also be a place where I never again have to hear the words "that's unfortunate" because of my skin color.

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Waking Up To The Truth – Insomnia in Ireland

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One of the most prominent and financially neglected subjects in general practice is mental health. A 2022 study concluded that approximately 42.5% of Ireland's adult population meet the requirements to be diagnosed with having one or more mental disorders.[1] Among these disorders is insomnia, which is defined as an overall dissatisfaction with sleep and the persistent difficulty to initiate or maintain sleep, that is estimated to affect 15% of all adult Irish residents.[1] This suggests that over 600,000 individuals may suffer from Insomnia. This essay will explore which factors contribute to insomnia's high prevalence in Ireland, the urgency of the situation, treatments implemented in Ireland and it's limitations, and how Ireland could address these issues.

Demographical and Environmental Determinants

Like most mental disorders, insomnia is very complex and can't be attributed to one single physiological change in either the mind or body, however there are a few factors that present most commonly in Ireland. The most broad category is age: individuals between 18-24 are more likely to have a mental disorder such as Insomnia.[1] Interestingly, being in university decreased the risk of developing a mental disorder despite most university students fitting the demographic bracket of 18-24, this could be tied to the more active social life and access to mental health resources such as counselling.[1]

People doing shift work were found to be 70% more likely to develop a mental disorder due to the disruption of their circadian rhythm which is the human body's biological clock that regulates both physical and mental changes based off light and dark.[1, 2] This aligns with the narrative of shift work, especially the night shift, being detrimental to an individual's health. This is a huge issue for Ireland as 15% of its workforce do shift work.[1]

Additionally, it has been shown that a child's EEG-derived sleep patterns are associated with that of their parents, especially when their mothers have insomnia.[3] Although there is definitely a genetic factor at play, it is also important to consider that children often spend more time with their mothers compared to their fathers. This could be a major reason as to why their sleep patterns are affected by their parents' insomnia.[3, 4]

The Cost of Insomnia

Insomnia has been shown to significantly impact both the physical and mental health of individuals, often resulting in serious consequences both medical or otherwise. Insomnia has been proven to be a form of chronic hyperarousal, which is a condition that leads to increased secretion of cortisol which is more commonly known as the stress hormone.[5] This is an example of chronic activation and dysregulation of the HPA axis which leads to an increased risk of cardiovascular disease, diabetes and other mental health disorders.[5, 6] This makes insomnia a serious candidate for co-morbidity that should definitely be further researched. Additionally, people suffering with insomnia are more likely to be hospitalised due to a stroke.[7] While the evidence linking insomnia and strokes has yet to be established, the correlation of insomnia and cardiovascular disease via the HPA axis may be a key piece to help solve this unknown.[7]

Individuals with insomnia, like those with any other mental disorder, are more likely to attempt to commit suicide.[1] Although insomnia is less strongly associated with suicide compared to other disorders such as psychosis, treating insomnia in the population would lead to a greater decrease in suicide attempts because it makes up the highest proportion of individuals with mental disorders in Ireland.[1] Revisiting intense work schedules, truck drivers in the US have been found to be involved in more motor-vehicle accidents if they had insomnia which can be a massive risk to the general population considering the robustness of the vehicle involved.[8] Insomnia clearly affects not only the physical health of individuals, but also puts the lives of others and themselves at risk.

Treatment in Ireland

There is no definitive cure for insomnia beyond addressing the root cause which may or may not be able to be treated. As a result, a lot of treatment for the condition focuses on management of symptoms rather than curing.[9] Sleep restriction and stimulus control therapy focus on the realignment of an individual's sleep schedule by restricting time in the bedroom that isn't spent sleeping and avoiding activities that encourage staying awake.[9] This starts with attempting to fall asleep for 20 minutes, leaving the room if the individual fails to fall asleep and repeating when they feel tired again.[9] Stimulus control therapy also includes the use of consistent alarms to encourage a consistent sleep schedule which whilst is great on paper, shift workers may find it difficult to keep to a certain wake up time when working very late hours.[9] Cognitive behaviour therapy is used to discourage unhealthy beliefs and behaviours which can increase the severity of the insomnia whilst reinforcing more positive ideas such as sleep not being the "be all end all".[9] Sleep hygiene and general advice both encompass habits such as avoiding food, alcohol and caffeine whilst leaving the bed to be a space for sleep and sexual activity only.[9]

Pharmacological treatments vary widely from milder, over-the-counter treatments such as melatonin to the more severe and off-license like antidepressants such as zolpidem and trazadone in the US.[9] One of the biggest issues with sleep health medication in Ireland is benzodiazepine compounds.[9] This class of drug is a well-known sedative that, depending on the specific compound, can induce severe hangovers in the morning that have been shown to cause falls and accidents amongst older patients.[9] Benzodiazepines are particularly dangerous due to the fact that they can present with withdrawal symptoms similar to insomnia and anxiety, this can lead to patients becoming dependent on benzodiazepines or similar sedatives which just replaces one problem with another.[10]

How Can This Be Improved?

Insomnia's complexities and unknowns make it hard to determine where exactly treatment is headed for the disease, but looking towards international solutions is a good first step. Unfortunately, it seems countries with lower insomnia rates such as Japan(10%) and the Netherlands(5.4%) still make strong utilisation of sedatives.[11, 12, 13] Japan however, is a more interesting case as they do not only use benzodiazepines, but also make use of a drug called lemborexant which has been shown to have less side effects and both improves insomnia and reduces benzodiazepine dosage in a patient.[12, 14] The country has a strong prioritisation of using safer drugs for first line treatment of insomnia like orexin antagonists such as suvorexant or melatonin agonists such as ramelteon.[12]

A common substitute for benzodiazepines is z-drugs such as zolpidem which are publicly perceived as a safer alternative, however they have been shown to be simply faster acting and shorter lasting which doesn't make them safer.[15] The 2022 study from the beginning points to how important the first 30 years of life are to developing a healthy adult human and that, despite not being done in the study, it is crucial to screen and test for mental disorders during young ages to ensure that these issues don't accumulate.[1] From a budget perspective, the WHO recommends that a government gives 12% of its healthcare budget to mental health treatment, Ireland only attributes 5.1% of its budget towards it as of 2021.[1] Ireland has only 22 acute mental health beds per 100,000 in the population which is substantially low compared to the EU average of 70.[1] These beds are specialised for all mental disorders and not just insomnia which likely means even fewer are available for individuals suffering with insomnia.

Cognitive behavioural therapy plays an essential role in non-pharmacological treatment of insomnia and with modern technology, the EU has reshaped its guidelines towards digital cognitive behavioural therapy to increase accessibility to all individuals.[16] Cognitive behavioural therapy being fully automated and available 24/7 makes it available to patients with no access to cognitive behavioural therapists specialised for insomnia which makes it an excellent choice for the first line of insomnia treatment in place of sedatives.[16] Polysomnography is a diagnostic technique that measure multiple physiological activities during sleep, it is still unclear whether it is actually necessary to the diagnosing of insomnia.[17] That being said, the lack of understanding of insomnia at a physiological level makes a strong case for further investigation into use of it to learn more about the disorder. Maintaining the use of polysomnography in conjunction with other forms of vital monitoring could lead to a better understanding of why insomnia increases the risk of multiple non-communicable diseases as previously mentioned.

So What Now?

Insomnia is without a doubt not only a prevalent, but complicated health issue that has international presence and needs more immediate attention than it currently gets. There should be more of a focus on increase in delivery of non-pharmacological treatments and discouragement of sleep-inducing medical drugs, especially strong sedatives such as benzodiazepines. Further research of the physiological root cause of insomnia and its links to non-communicable disease are essential to developing better treatment. These issues can be resolved through reorientation of governmental funding , increasing access to mental health resources and overcoming the unhealthy stigmas of “crunch culture” which encourages individuals pushing themselves over the edge for work.

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Reimagining General Practice: Creative Pathways to Address Ireland's GP Crisis

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In light of the GP crisis in Ireland, the public turns to divine intervention, "praying whatever infection they have clears up." [1] The current depletion of resources in GP clinics is becoming ridiculous as patients are being handed back their GP cards and told to wait for weeks for a 10-minute appointment with an overworked doctor. However, germs and pathogens don't mind the wait as they cause havoc, disrupting patients' lives. Junior doctors, deterred by relentless workloads and limited support, opt for Australia or Canada instead, leaving Ireland with a shortage of GPs. Best-case scenario, the Irish turn towards overcrowded A&Es or privatized healthcare that costs an arm and a leg. This essay explores the current challenges facing Irish general practice, including access shortages and medical emigration. It then considers innovations, from mobile GP units to rethinking medical education, before reflecting on how Ireland can reimagine its primary care system for a better future.

Addressing Overcrowding Through Innovation

Overcrowding and long waits have become the norm at the local clinic. Securing an appointment often feels like a game of chance, with patients holding GP cards being turned away at the front desk. In Dublin, one doctor reported that their clinic is forced to refuse "20–30 patients" each week [2]. While this may sound like a challenge, the broader context is striking: the number of patients waiting for primary care has increased by 200% between 2018 and 2023 [3]. Now, primary care is not just coughs and colds; GPs are the first point of contact for the majority of patients, in addition to vital public health responsibilities like childhood vaccinations and maternal care. Yet patients are being left in dangerous limbo. One woman in Leinster waited two months to have an unexplained bruise on her breast examined, describing the experience as "not a minor inconvenience; it is a complete failure" [1]. Paradoxically, the HSE runs breast cancer awareness campaigns that emphasise early detection, yet the same system cannot deliver timely access to the very services required, despite the treacherous progression of the disease. This contradiction reflects a deeper systemic issue, highlighting that clinics burdened by overcrowding, understaffing, and relentless pressure struggle to implement the practices they support.

It doesn't have to be this way. The German healthcare system has demonstrated how the integration of non-physician roles within general practice can relieve pressure on GPs. Neeltje et al. (2012) studied the impact of the AGnES-concept (AGnES: GP-supporting, community-based, e-health-assisted, systemic intervention) in alleviating the patient burden placed on general practitioners [4]. In this model, AGnES practice assistants were delegated GP home visits, achieving an average capacity of 1,376.5 visits per year. According to calculations, this translates into 360.1 GP working hours saved annually, which physicians could use to treat approximately 170 additional patients per quarter. Beyond relieving overcrowding, this initiative strengthens connections with vulnerable members of society, especially the elderly. In the current crisis, many GPs understandably avoid home visits, yet these are crucial for frail, immobile, or cognitively impaired seniors who cannot reach a clinic without support. Practice assistants bridge this gap by assessing patients at home, evaluating their living conditions, medication adherence, and support systems, and referring to a GP when needed. This approach not only supports the elderly population but also mobilises the wider primary care team to directly address the immense pressure on clinics. Serious adoption of solutions like the AGnES concept could significantly reduce the number of elderly patients attending GP clinics by expanding home-visit capacity. This is particularly vital given that 93.8% of community-dwelling older adults aged 65 years or above visited their GP at least once in the past year [5].

Improving Accessibility in Primary Care

Visiting a clinic can be difficult. Many are at full capacity and physically getting there is often a challenge. A reader of *The Journal* described how her doctor of 30 years is a two-hour drive away, saying, “It’s literally a day trip. Fasting bloods are a dizzy mess.”[1] Getting an infection or needing a vaccine should not require a road trip. Having to travel such distances for basic tests is especially unreasonable when urgent care is needed. This often results in delayed treatment, worsening conditions, and heightened anxiety. Moreover, not everyone has the means to travel. Many individuals cannot miss work, have children to tend to, cannot physically travel due to ailments or injuries, and sometimes, transport is just not accessible in their area. These barriers place a considerable burden on patients, exacerbating health inequalities.

Another reader, a new mother, shared her struggle getting GP care for herself and her children after moving [1]. In Meath, she called six clinics and was repeatedly turned away. Her baby was assigned a GP, but she still waited weeks for an appointment and had to use expensive private care. She even paid for vaccines that are ‘supposed to be free’ during pregnancy. Under the Maternity and Infant Care Scheme, expectant mothers in Ireland are entitled to maternity care, even without a medical card [6]. These are not isolated stories as they reflect a growing nationwide crisis that threatens public safety. Access is fundamental to the quality of care the HSE strives for, with GPs as the system’s first line.

What if the clinic were just down the road? An interesting proposition to combat difficulties in accessibility is mobile clinics. Similar to ambulances, these vehicles would be equipped with essential medical equipment and staffed with trained physicians. This initiative may improve access to GP services, helping to deliver primary care without the costs associated with opening new, expensive practices. O’Carroll et al. (2016) conducted a fascinating study examining whether the implementation of mobile health clinics (MHCs) improved access to healthcare among Dublin’s homeless population [7]. For context, MHCs were established by Safetynet in 2010, offering routine primary care services including needle exchange, blood tests, and vaccinations. Results indicated that 52% of patients did not possess a medical card and would otherwise have had no access to primary care; over half stated they would not have sought treatment without the service, and 16% would have resorted to emergency departments. These findings clearly illustrate that mobile clinics can improve access in vulnerable populations. The study delves deeper and discovers that the quality of care did not deteriorate in mobile clinics. Notably, 91% of users rated the service a 10/10 while GP registrars involved in the programme reported reduced negative stereotypes, increased empathy, and enhanced understanding of homelessness. This fuels advocacy and compassion, helping prevent discrimination in their future practice. Building on the success of MHCs, the HSE could implement similar mobile clinics to reach underserved rural populations and urban communities facing excessive overcrowding, thereby improving equity and continuity of care.

Reinventing Medical Education

An easy solution to overcrowding would be to hire more doctors, but even young physicians are not ready to take on Ireland's challenges. In the past few years, Ireland has faced a 'brain drain' with young doctors moving abroad in pursuit of better opportunities and greater work-life balance. According to Halon et. al, 2024, newly-graduated physicians travel to four main nations: Australia, New Zealand, the United Kingdom, and Canada [8]. The study shows that since 2014, over 300 Irish-trained GPs are employed in Australia each year, indicating that the migratory trend is established and steady. Overall, by 2021, 1077 Irish-trained GPs were registered in the UK, Australia, and New Zealand. For context, in 2024, 4,370 GPs were practicing in Ireland [9]. This data represents that there is a significant drain of resources. But can we blame the young doctors? Gouda et. al (2015) corroborate emigration data and present key reasons for doctors leaving Ireland [10]. Researchers described that there is a lack of clarity around postgraduate training, difficulty obtaining work opportunities, diminishing working conditions, and lower salaries within the Irish healthcare system. To elaborate, the study found a correlation between students who don't understand postgraduate training in Ireland and those intending to emigrate. Despite training opportunities growing, the relay of information is faulty, meaning that better promotion is in order. Furthermore, the study states that "career opportunities were the most frequently given reason influencing respondents' intentions to emigrate (85%)," though the HSE is currently increasing the number of consultant positions. In 2024, Minister for Health Stephen Donnelly announced the Public-Only Consultant Contract employing 380 new consultants and 1543 existing consultants [11]. This contract ensured an important step towards a universal, single-tiered healthcare system, as, under this new contract, consultants cannot treat private patients in public hospitals. Moreover, for doctors who have a job in the HSE, their work-life can be incredibly complicated due to working conditions in public hospitals. Difficulties tend to pile up due to the immense workload and the increasing number of patients. Factors like staff shortages, irregular breaks, and being undervalued by the community bring down the standard of care and promote irritability amongst employees [10]. Improving working conditions is clearly vital to keep Irish doctors in Ireland. Lastly, salary tends to be a key component of the brain drain. General practitioners tend to be paid less than other specialities, and pay in the public sector is comparatively worse. It is given that salaries depend on external factors like location and expertise; however, lower pay does push debt-burdened doctors towards other countries or private clinics. It is important to recognise that physicians especially face substantial student loan debt with medical school and specialisation, conveying the importance of fair pay for all healthcare workers. Despite multiple factors influencing emigration, there are creative solutions medical institutes can implement to increase the number of Irish-trained GPs.

The pathway to becoming a GP is long and arduous, ask any medical student. Simply getting into a medical school is a feat. The University Times (2025) establishes an intense competition, stating that in 2024, approximately 14,000 students applied for about 1,000 medical school places; “a ratio that leaves many talented individuals without the opportunity to pursue their dreams of becoming doctors.”[12] Additionally, amongst students who did get in, how many actually dream of being a general practitioner? Gouda et. al (2016) conducted a study on medical student perceptions of general practice, identifying multiple factors that medical students felt deterred their decision to pursue this specialty [13]. Obstacles included inadequate access to diagnostic imaging, in addition to 91.6% students expressing that the aging population is a challenge, with 72.5% indicating that patients are becoming more complex. It goes to say that every field has its challenges, but general practice does seem to be one of the worst perceived. Not only are better promotion and curricula required from medical schools, as the *Royal College of General Practitioners* has suggested, but possibly more direct pathways [14].

In the midst of Ireland’s ongoing GP crisis, exacerbated by medical student emigration and growing competition, it makes sense to introduce an integrated general practice pathway. This would be an exciting new opportunity for secondary students, being a dedicated university track running alongside the medical programme. This course would be designed to train and inspire a cohort of future GPs. The pathway would begin with one to two years of foundational clinical learning, followed by immersive placements in GP clinics, with a particular focus on early exposure to rural practices across Ireland (to improve healthcare access). Teaching would involve experiential learning, focusing on modernizing primary care and community engagement. Students could engage in health-promotion initiatives, including vaccination campaigns and rural screening programmes, thereby strengthening links between universities and local communities. Most importantly, the course could re-frame general practice as an intellectual, leadership-driven field that sits at the forefront of the healthcare system, shifting attitudes from ‘I fell into GP’ to ‘I chose GP’. By gaining early and meaningful experiences, students would develop a well-informed appreciation for the value of general practice, form lasting connections with mentors, and feel more inclined to remain in Ireland after qualification. In the longer term, such a pathway could also inspire more pre-health students in secondary schools to pursue careers in medicine and primary care. Though it is a significant institutional change to create an entirely new course, it aligns with the HSE’s goals of recruiting Irish-trained, patient-centred general practitioners. If medical schools aim to increase the number of seats regardless, it may be an interesting case study to implement with a small cohort of incoming students to assess its feasibility and impact. A similar programme is run by the National Health Service in Scotland, the rural training programme, brings post-graduate students to remote practices around the country [15]. It's known as a unique experience, allowing trainees to learn about rural medicine and engage with vibrant communities. This framework demonstrates that aligning medical education with population needs can influence future physicians to pursue careers in general practice.

Reflecting on the Irish GP Crisis

Overcrowding, inaccessibility, and emigration are pressing challenges that understandably fuel anxiety among both healthcare providers and patients. Yet these issues also invite us to think differently. As Ireland strives to meet Sustainable Development Goal 3 (SDG 3): 'Good Health and Well-being', creative and evidence-based solutions could help the nation overcome its GP crisis, even positioning it as a model for healthcare reform worldwide. While such solutions would require significant financial investment and agreement among multiple stakeholders, the long-term benefits for primary care delivery and public health would be substantial. Most importantly, these efforts must keep people at their core. They range from healthcare assistants supporting vulnerable populations to mobile clinics improving accessibility and new educational pathways encouraging medical students to remain and serve in Ireland. Ultimately, Ireland has the opportunity to safeguard the future of its most essential specialty. The public, waiting in overcrowded clinics, deserves a healthcare system that is patient-centred, effective, and led by compassionate, fulfilled professionals. By reimagining GP training and service delivery, the current GP crisis could become a chapter in a history textbook.

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A win for women’s health but at what cost

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Introduction

In one single morning in any GP surgery, you might encounter a lady looking for relief from her menopausal symptoms, a young adult waiting six months for their referral to psychiatry and a parent desperate for disability services which barely exist. Each story is different and none is less important, yet it seems our health system listens to some voices more than others.

June 1st 2025, marked a historic moment in Irish healthcare, as the State began covering the cost of hormone replacement therapy (HRT) [1]. It was rightly celebrated as this initiative represents real progress and long-overdue recognition of women’s health as a major public health issue. By removing cost barriers the scheme aims to make treatment accessible to all who need it [1].

Yet, it is hard not to question whether other areas may have been more deserving of this funding or ought to have been addressed first. This is not to diminish the importance of women’s health or the very real and life altering suffering menopause can cause. Rather to question the priorities of our health budget and those who govern it. Chronic underfunding of mental health and disability services (to name but a few) continues to place immense strain on patients and their families, as well as the GPs who serve them, yet these areas rarely make headlines. It prompts a troubling thought; are health initiatives in Ireland increasingly being shaped not by need, but by political optics and popularity.

A turning point for women’s health in Ireland

The Women’s Health Action Plan 2022/2023 outlined a series of initiatives designed to improve and advocate for women’s health in Ireland [2]. Launched on International Women’s Day by the Department of Health in partnership with the HSE, the Women’s Health Taskforce and multiple stakeholders, it represented Ireland’s first comprehensive national framework dedicated specifically to women’s health [1,2]. The plan was informed by extensive ‘listening exercises’ with women of all ages and backgrounds, as well as with healthcare professionals. It aimed to capture the lived experiences and systemic barriers faced by women accessing healthcare [3,4]. Among the most notable measures emerging from this strategy was the introduction of free HRT for all women in Ireland, enabling access to prescribed HRT products from participating pharmacies without any government levy or dispensing fees [6].
This move was widely welcomed as a progressive step towards equity in women’s healthcare, acknowledging the impact of menopause on quality of life and ensuring cost would no longer act as a barrier to treatment. However, it also became one of the most publicly visible outcomes of a broader women’s health agenda. It gained significant attention and debate

particularly in regards to delays in rollout and logistical issues such as pharmacy dispensing fees [6]. Moreover, it demonstrated how healthcare priorities can be chosen, communicated and implemented in Ireland.

The history of women's health in Ireland

Ireland's history of women's healthcare has been marked by a series of controversies, from the mother and baby homes to the more recent Cervical Check screening scandal [7,8]. These events highlight the longstanding systemic failings in the provision of care for women. Both instances exposed deep gender inequity and have contributed to a national loss of trust in healthcare services specifically aimed at women [9].

Media coverage following the Cervical Check scandal was extensive, underscoring the issue as not merely just failures in cervical screening, but as indicative of broader, ongoing neglect of women's health in this country [2]. This includes a lack of research and poor treatment of areas such as menopause, endometriosis and PCOS, among others [2]. The combination of scandal, media attention and public engagement helped shift the national discourse from a focus on single program failure to a broader focus on systemic gender based healthcare inequalities, paving the way for subsequent initiatives such as the Women's Health Action Plan and the measures like free HRT access which came from it [1,2,5]. Reflecting on this, I think that it is plausible that policymakers in Ireland needed a tangible success story in women's health; a visible or reparative gesture after decades of neglect.

Political opportunity and public visibility

While the introduction of free HRT and the Women's Health Action Plan represents a huge step forward for women's healthcare, it is also important to think about the political context in which these initiatives were launched. Policy analysts have noted that the highly topical nature of women's health, particularly menopause and HRT, makes it politically appealing, as it generates public attention and media coverage in a relatively short timeframe [1,2]. It seems likely that politicians and their parties may have seized upon the momentum created by public outrage over these forementioned historic failings, to demonstrate a sense of responsiveness and commitment to gender equity, even in cases where their past policies or voting records (conservative stances on reproductive health) may not have consistently aligned with these priorities [10].

This strategy reflects a broader trend in healthcare policy, where initiatives that are "headline-friendly" or emotionally resonant are sometimes prioritized over other areas that are less visible but critically underfunded [11]. The prominence of women's health in public discourse, combined with the timing of the HRT rollout, suggests that political optics and public relations considerations may have influenced the decision-making process as much as, or even more than, urgent clinical need or long-term healthcare strategy.

The daily reality of General Practice

It is widely accepted that GPs are under immense pressure to meet the expectations of their patients. This becomes increasingly difficult when politicians make well intended promises without fully considering how they will be implemented. National policies quickly become real in general practice. As the meeting point between the public and the healthcare system, GPs are the first to hear the frustrations and hopes. They are the ones who are left to explain new entitlements, adjust prescriptions and manage expectations. They also witness, more than anyone, the ripple effects of both well-funded and neglected services.

In one particular GP practice in Louth, I was told that current wait times for assessment of for children with additional exceeds two years. This has left many parents outsourcing to private providers often incurring massive financial losses. At the same time private providers, such as the Talbot group, which offers care for people with intellectual disabilities have experienced substantial financial gain as long term public facilities have been systematically closed [12]. The lack of investment in public provision is lining private sector pockets. This is a pattern seen all over healthcare from orthopaedics to ENT, where delays are increasingly being met with solutions like the national treatment purchase fund and the cross border care schemes [13].

The introduction of free hormone replacement therapy (HRT) was immediately felt in primary care. Conversations around menopause became easier, access more straightforward and many women experienced a genuine sense of relief. Yet GP surgeries remain filled with the same patients from before, still struggling to access timely mental health or disability supports. At the same time, they are becoming even busier with new patients eager to learn what additional entitlements they may now have, often influenced by what they have heard in the news.

This isn't new, these areas have long been underfunded and under resourced and it is an ongoing pattern that I argue is due to a lack of public visibility which makes political attention harder to attain. That is to say that this policy, while positive, has shone a bright light on one corner of healthcare while leaving others in shadow yet again. Additionally, it must be remembered that general practitioners offer their patients care from the cradle to the grave and it is imperative that they are not stretched any thinner than they already are.

Mental health and disability services in Ireland

The contrast between the success of free HRT and the ongoing neglect of other services underscores a broader issue; healthcare policy in Ireland doesn't aim to represent those whose voices are unheard nor ensure equity for all patients and not only those whose concerns capture public attention.

Mental health and disability services in Ireland are two of the many services that continue to face significant challenges, including long waiting times and limited access [11,14,15]. Despite increased funding in recent years, these issues remain deeply entrenched [16]. In 2023, for example, the Health Service Executive (HSE) acknowledged that prolonged delays in accessing essential mental health care were still widespread, with previous commitments to reduce waiting times not being met [17].

In an era where mental health concerns are increasingly prevalent, it is troubling that these systemic shortcomings do not receive the same level of public or political attention as other health crises. This disparity highlights the urgent need for a more equitable approach to mental health provision in Ireland as well as its funding. Similarly, disability services remain chronically underfunded [14]. Many people with disabilities or families of children with disabilities continue to face restrictive means testing that limits access to essential supports and therapies [18]. In short meaning that people with a disability do not have automatic free medication or healthcare provision. It is concerning that such fundamental issues and such vulnerable population groups attract comparatively little political focus.

This is not unique to Ireland and unfortunately is a trend seen globally. A study conducted by a research team at the university of Bristol (the Confidential Inquiry into Premature deaths of People with Learning Disabilities/ CIPOLD) demonstrated that the quality and efficacy of healthcare provided to patients with learning disabilities was often suboptimal [19]. Many practitioners admitted that they are unaware of how to appropriately care for these patients and the report showed that people with learning disabilities more were more likely to die from causes that were potentially preventable if good quality healthcare had been provided [19]. The report reinforced the urgent need for change at a systemic level within the NHS and considered the outcomes a ‘shocking indictment of services which profess to value individuals and to personalise services according to individual need’. Notably, this report concluded that 42% of deaths among people with learning disabilities were premature [19]. The latest Learning Disability Mortality Review (NHS) revealed that the average life expectancy for people with learning disabilities was 23 years young in men, and 27 years younger in females than the general population [20]. However, surprisingly it revealed that the main issues contributing to these premature deaths were delays to accessing treatment, issues with identifying needs and providing appropriate care [19]. These are sobering statistics.

Patient advocacy and outcomes

In 1971, Dr Julian Tudor Hart introduced the inverse care law, which proposed that the availability of good medical care tends to vary inversely with the need for it in the population served [21]. This idea remains totally relevant today, as those with the most complex and challenging health and social care needs, such as those with mental health difficulties or those with disabilities, often face the greatest barriers. This highlights the need for advocacy on behalf of these more vulnerable population groups. It has been demonstrated time and time again that advocacy and public representation not only improves access to services but also enhances health outcomes and overall quality of life for people living with disability [22]. Knowing what we know then, with regards to this inverse care law, it is clear that resource delegation should not be based on political popularity but by genuine need.

A personal perspective

Personally, growing up with a sibling with a profound intellectual disability and ASD has shaped my outlook on the themes discussed throughout this essay. I have witnessed first-hand how inequity in the distribution of healthcare resources can affect not only an individual but an entire family unit. The lack of access to appropriate supports, therapies and care, places immense strain on families and highlights how those with the most complex needs are often left behind in our health system. It often struck me was the inherent unfairness.

Owing to this, when the free HRT scheme was first announced my initial reaction was one of slight frustration. This was not at all an opposition to improving women's health in this country but more so that it highlighted how certain areas of healthcare appear to be so much more of a priority than others. It again seemed representative of a system driven by visibility. HRT was already available under the General Medical Services (GMS) scheme or the Drugs Payment Scheme (DPS), depending on income level, which to me represented a fair approach. The universal rollout, while undoubtedly beneficial to many, seemed to reinforce an imbalance in how we allocate limited resources. By offering more to those already within reach of care, while those in greatest need continue to wait.

Conclusion

The provision of HRT illustrated that healthcare resource allocation may sometimes be influenced by political appeal. While it represents a significant and momentous step forward for women in Ireland it also highlighted the ongoing inequities faced by other, less visible patient groups. Many individuals with complex or urgent healthcare needs continue to receive insufficient attention and support. I have seen first-hand how such gaps affect families and individuals and it is clear that they don't receive the same attention.

Achieving true equity within our healthcare system requires that decisions be guided by genuine need and not political expediency. Only by prioritising those who are most vulnerable can we ensure that progress in one area does not come at the expense of another.

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The Adventures and Perils of Home Visits

Author: Leah Kogan, Undergraduate

“Sit up in bed, before eating a lollipop”. A simple enough sign, the work of maybe two minutes on the computer and another minute to print and tape it to the wall across from the patient’s bed. Yet this simple, albeit odd, “treatment” reduced the patient’s emergency room visits, and subsequent hospitalizations for aspiration pneumonia, by almost 100% in the following year. After months of seeing the patient in the office, receiving their hospital discharge notes, and taking several extensive histories trying to get to the root of the recurring aspirations, it wasn’t until we (my GP preceptor and I), stepped into her home, saw her admittedly impressive collection of thimbles, and noticed the small pile of lollipops on her nightstand did we find the culprit. She was able to swallow normally but, due to her midline hernia, as soon as she laid down, she immediately regurgitated. This, alongside her poor mobility, was the perfect combination for recurrent aspiration pneumonia. Until that simple sign. In modern days, a home visit is an odd enough thing to explain. Even when I was younger a doctor’s appointment meant a half day off school, and most importantly a post-visit treat. The idea of a doctor visiting my home felt quite foreign. Historically though, that was not always the case.

Home visits are categorically unique in how much information they allow you to capture about a patient, leading to a better understanding of their full story. In the past, home visits were not an exception, but rather the rule of General Practice. A doctor in the 1800s evokes images of a knowledgeable gentleman walking around with a heavy black bag full of intimidating tools, including speculums, dilatators, leeches, and even trephines (1). They’d be summoned to a patient’s home and would come rushing in, ready to deal with all manner of situations from births, to oozing wounds, to simple cases of the vapours. Originally, home visits were necessary due to the fact that many patients couldn’t travel to see a physician; either because they didn’t have available transport or because they were too acutely unwell to travel (1, 2). As technology, transport, and hospital infrastructure improved, the need for home visits diminished, becoming increasingly unnecessary and, in some cases, a waste of valuable time and resources. Alongside technological advancements, the field of medicine has experienced unprecedented expansion in the last few decades. With the creation of more specialized fields, the number of general practitioners has fallen as more physicians pursue the increasingly narrow and specific scopes of practice. In the 1950s, general practitioners were making upwards of 15 home visits per day (3). Nowadays, home visits make up less than 1.3% of the daily appointments within the Irish healthcare system (3, 4). But those are the questions, aren’t they? Should home visits continue to be part of general practice, are home visits truly a waste of time for the patient, the doctor, and health resources in general?

For all their clinical and emotional rewards, home visits are time-consuming, logistically complicated, and frustrating at times. During one of my more rural GP placements, home visits were done about once a week, usually on a Wednesday. On these home visit days, we would see several patients who were home bound, either due to physical or psychological reasons, or because they were palliative. In a rural area, patients can live quite far from the practice, some being about 40-60 minutes away. In addition, the actual appointment times were quite narrow, and the presence of family members led to demands on the physician's time, first by constraining it, and then by generating numerous questions to address. All of this resulted in home visits taking at the very least an hour, and that's if it was a routine visit. However, home visits aren't routine by the most basic of standards. The realities of a physician entering a patient's home can be a very vulnerable position for the patient, leading to heightened emotions and more defensive behaviours. Consequently, this can also make the situation more precarious for the physician, and as a woman; personal safety is always a consideration (5). Additionally, we also need to consider boundaries: as a GP they are a vitally important aspect within professional, and personal lives. During a home visit, it is impossible to not feel these boundaries blur. After all, you are seeing the patients in a very personal setting. Another boundary that can be blurred to facilitate a home visit is the sharing of the physician's private number with the patients and their families. The increased familiarity can lead to patient's contacting physicians for non-urgent matters, and, as I have observed on several different occasions, it can create a sense of expectancy towards the physician's time and expertise. In medical school, we are taught the importance of professionalism. Yet, this particular skill set is not one that is a part of that curriculum. The ability to create and uphold boundaries is something that typically comes with time, experience and, unfortunately, an inciting incident. As such, including home visits in your practice should be done with awareness and an acknowledgement of the difficulties in maintaining professional boundaries.

Despite this, we cannot forget about the lollipops. It is undeniable that home visits offer a degree of knowledge, and perspective, about the patient and their life. The superpower of general practice lies in the longitudinal relationship between patient and physician. Whether positive or negative, entering a patient's home and providing care at the bed side (or couch side, as it may be), opens a door to look into the patient's overall well-being. I recall a home visit where I understood for the first time the illness of hoarding. We couldn't use the front door; it only opened only about halfway. The physician, who had visited several times before, knew this, and when we entered, I understood why. A thick layer of dust covered the entire home, and we were greeted with towers of video games, old wires, and an impressive amount of computer mice. As we wove throughout the stacks of computer parts, having to turn sideways at one point to squeeze through an entryway, we came to the patient's couch. He was a kind, friendly, well-kept man who was excited to see the physician. If I saw him in the clinic, I wouldn't suspect that he hasn't left his home in over 6 years, or that he has struggled with his mental health since his wife passed away. By seeing him in his own home, where he felt most comfortable, we were able to open a line of communication based on trust and vulnerability. This in turn made the patient more open to accepting the resources that the physician offered, including a telehealth appointment with the community psychologist.

Despite the difficulties of home visits, the practical benefits are quite clear. Whether it is lollipops at the bedside or the beautiful but rug in the living room, a home setting allows physicians to free themselves from the clinical judgements that are made based on a 15-minute interaction.

In medical school, we are taught to not only listen to the patient, but to observe them. Every single physical exam begins with a general inspection. Does the patient look comfortable at rest? Can we see their work of breathing? Are they in visible pain? What objects do they have at the bed side; a nebulizer, GTN spray, a pain pump? A home visit offers us more pieces of the puzzle that we can use to better understand the patient's clinical picture, helping us to guide the treatment that would best support the patient. Without a doubt, a doctor's knowledge of a patient's underlying social life should influence the overall management. However, in a large, multi-practice Norwegian study, only 17% of consultations were influenced by this aspect of a patient's history (6). The changes in management could be something as simple as longer consultations or different advice offered, or a change or increase in prescriptions. One of the most common changes in response to knowing a patient's social problems was increasing the consultation time and providing advice. In short, knowledge of a patient's social problems promotes communication, and deepens the relationship, more than changing any physical treatment (6). In general practice we do not treat patients in a vacuum; their background is a very important consideration, and home visits are one of the capable ways to obtain information about a patient's environment.

Home visits can certainly be costly in healthcare resources; however they can also prevent more costly resources due to early intervention. Anecdotally I have noticed how home visits can reduce hospital admissions, but in literature, it also shows that home visits decrease the average length of hospital stays from 17.5 to 13.7 days (7). Although home visits don't necessarily decrease the number of medications or emergency room visits, by reducing the length of hospital stays, it has a drastic effect on both the associated financial cost and, more importantly, the patient's comfort. As healthcare workers, we are all familiar with the dangers of hospital acquired infections and their impact on a patient's morbidity and mortality (8). Many hospitals have entire teams dedicated to reducing nosocomial infections, but why should the work wait to start once the patient is in the hospital? Preventive care is the best care, and if a single home visit can decrease the length of a patient's hospital stay, it could stop the vicious cycle of nosocomial infections and subsequent deterioration in its tracks (8).

Home visits were created to increase accessibility to healthcare. In the past, when patients were not mobile or have access to transport, it was the only way they could receive care. Today, telehealth is beginning to play an increasingly significant role in healthcare. The COVID-19 pandemic accelerated technology's role in healthcare, through video appointments, or virtual wards transforming how care is delivered. While , technology continues to shift the healthcare workspace. In our modern era, virtual workspaces are often seen as a substitution for home visits, and the ability for technology to reach remote patients remains unparalleled. While it is convenient, allowing for rapid follow ups and continuous monitoring, it does not replace the insight into a patient's life that a home visit can provide. A video camera can't capture subtle physical signs, the overall living conditions, or the family interactions. Family dynamics, and interactions are a huge component of home visits. Is the family supportive, is the spouse able to take care of the patient, are there financial strains, or ulterior motives between careers. In medical school, I was taught that 90% of the time you can figure out a patient's diagnosis from the history and exam. A telehealth appointment absolutely has huge benefits and advantages, but it cannot replace an exam and physically seeing a patient in their home. As general practice and healthcare continue to evolve, I think the future holds a combination of both telehealth and home visits, they are not in competition but rather are both important tools that offer support for different aspects of patient care.

It was during a home visit in a rural area that I opened the patient's fridge to grab a water filter and saw that he had no food. At 94 years old, he didn't own a car and wasn't as mobile as he once was. Because of this visit, my preceptor and I were able to take him to the grocery store before arranging for a weekly grocery delivery and daily home care. As I complete my rotations, I've come to realize that home visits are some of the most important and educational parts. They represent the core of general practice and the goal of patient centred care. To care for a patient as a general practitioner means to care for them in the full context of their lives, from their social problems to their work problems, to their physical problems too. Home visits offer an otherwise unknown dimension to the patient, and with better understanding of the patient, we are in turn better able to treat the patient. Long after a home visit ends, what stays with me is not the medicine or the physical exam, but rather the collection of thimbles and the pile of lollipops on a nightstand.

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Lost in Translation: General Practice in a Multicultural Ireland

Author: Mitra Javadpour

Introduction

A thirty-nine-year-old Ukrainian refugee presents to the GP clinic in a wheelchair. On examination, there are no clinical findings to explain her immobility. The patient informs the GP that she uses the wheelchair due to “leg pain” — well, the interpreter informs, we can only assume this is a direct translation. The GP, frustrated by repeated visits and lack of progress, gently suggests transitioning to a walker—but a week later, the patient returns in tears, her pain worse than ever.

This is an encounter I witnessed during my undergraduate primary care placement that left me wondering: Would this consultation have gone differently without the barriers of language and cultural misunderstanding?

In this essay, I will explore how language, culture, and systemic design create barriers to health equity in Irish general practice—and how these challenges can be addressed through education, collaboration and policy change to better serve Ireland’s growing migrant population.

Language barriers

With 12% of Ireland’s population being non-Irish citizens (CSO, 2023) , communicating with patients who have limited English proficiency has become an issue for most GPs (Condon, 2023) . Although many migrants possess good English, the 2016 Census showed that over 86,000 people in Ireland consider themselves to speak English “not well” or “not at all” (Condon, 2023) . This number can only have increased in recent years with the rising number of migrants and refugees immigrating to Ireland (CSO, 2025) .

A survey of 134 GPs and GP registrars working in Ireland was carried out on behalf of the ICGP between 2021 and 2022 (Condon, 2023) . According to this survey, language barriers impacted a consultation on a weekly basis for 37% of GPs and on a daily basis for 19% (Condon, 2023) . Only 20% of GPs worked with a formal interpreter during consultations when patients had limited English, while 90% of GPs reported using family members as interpreters (Condon, 2023) .

The most important finding from this survey, in my opinion, is that 83% of respondents “could recall an incident where a language barrier adversely affected patient care” (Condon, 2023) . This figure, although highly concerning, is not surprising, especially considering the number of GPs resorting to patients' family and friends as interpreters. Confidentiality is at the heart of primary care. However, in these instances, it is being breached. Why? Going back to the ICGP survey, only 33% of GP participants knew how to arrange a formal interpreter, with 84% expressing interest in education on migrant health (Condon, 2023) . These results are a blaring sign that there is a major gap in our medical system when it comes to training and support around migrant health for GPs.

The HSE has created a few resources in the aim of bridging the language gap. Such resources include the Emergency Multi-Lingual Aid which was developed by the HSE to assist frontline staff in communicating with patients who do not speak English as their first language (HSE, 2023) . The aid is designed for use at emergency departments and maternity hospitals but could also be useful in primary care settings (HSE, 2023) . It includes visual cues, patient-led questions in eighteen languages, as well as language identification cards to aid in assessments (HSE, 2023) .

However, the HSE clearly states that the aid is only meant for use “prior to requesting the services of an interpreter or while awaiting the interpreter’s arrival” (HSE, 2023) . Unfortunately, in many cases, accessing an interpreter is not always feasible. Out of 368 questionnaires completed by Ukrainian refugees in Ireland, about 55% of respondents reported requiring a translator when attending general practice (O'Reilly N, 2025) . However, from the same sample, only 33% of respondents were offered a translator (O'Reilly N, 2025) .

Cultural misunderstandings

Even with language barriers removed, distinct cultures pose unique challenges to building a good rapport with patients. In some cultures, doctors are viewed as more paternalistic figures. For these patients, the Irish GP - who’s had ‘patient autonomy’ and ‘friendly demeanour’ drilled into them since medical school - could inadvertently come across as unprofessional or even incompetent. A common piece of advice heard in Irish medical schools for connecting with patients is ‘crack a joke’. Unfortunately, this well-meaning advice could have the opposite effect when met with patients from certain cultures, jeopardising their trust in their doctor. It is crucial that GPs are sensitive to cultural differences and can adjust their communication style accordingly to ensure all patients feel comfortable confiding in their doctor.

A 2021 article published in the Irish Times discusses research into the experiences of Muslim women in Ireland’s maternity care settings (Wilson, 2021) . The research found that 15% of Muslim women experienced incidents of verbal abuse, including being shouted at and told to remove their headscarves (Wilson, 2021) . About 74% of healthcare workers were unaware of any policies around providing culturally specific care for Muslim women (Wilson, 2021) . Perhaps the most concerning finding of this report was that over one in three healthcare workers claimed to have witnessed racism and discrimination towards Muslim women by other health workers (Wilson, 2021) . Although this study was not carried out on GPs, it still indicates a strong need for greater intercultural understanding and tolerance in our healthcare system as a whole.

The ‘HSE Intercultural Guide,’ written for all health professionals, profiles 25 distinct cultural communities present in the Irish population (HSE, 2025) . Although a useful guide, it should not be taken as absolute as this could risk categorising patient groups into stereotypes. Doctors should be taught to ask patients about their preferences - for example, ‘what would you like to be called?’ ‘What are your expectations for today’s visit?’ etc. This individualised approach avoids problems that could arise from making assumptions about patients based on generalisations. Another drawback of the ‘HSE Intercultural Guide’ is that it is 132 pages long, which GPs may find overwhelming (HSE, 2025) . I believe the HSE is making progress in terms of generating information for GPs on how to cater to a multicultural population. However, the information has not been made accessible or manageable for GPs.

Systemic design:

Multiple factors can impede migrants’ access to health services (Barlow P, 2021) . Aside from potential language barriers, socio-economic circumstances, discrimination, lack of health information, and difficulties navigating the complex Irish healthcare system all provide obstacles to migrants accessing health services (Barlow P, 2021) . A ‘Healthy Ireland’ survey carried out in 2016 found that non-UK migrants in Ireland were less likely to visit a GP than those born locally (Barlow P, 2021) .

This survey found that the uninsured rate amongst the non-UK immigrant population of Ireland is higher than the rest of the sample, and also reported that immigrants are less likely to be covered by a medical card (Barlow P, 2021) . Even for those born and raised in Ireland, obtaining a medical card can be an overwhelming task, let alone for migrants unfamiliar with the Irish system. A 2011 qualitative investigation concluded that there was a lack of awareness on how to engage with the Irish insurance system and considerable concern about the cost of accessing primary care among migrants in Ireland (Barlow P, 2021) .

During GP placement this year, my eyes were opened to disparities between the workings of our national health service and those abroad. I observed that Ukrainian patients appeared confused by the Irish system of ‘gatekeeping’ investigations. Speaking anecdotally, based on the Ukrainian patients I have encountered; they expressed surprise at the inability to access advanced investigations such as MRIs on demand, the long waiting lists were unfamiliar to them, and many are baffled by the inefficiency of the Irish medical system.

Many migrants may not even be aware of the concept of a GP, as they do not exist in all countries. As primary care providers, GPs and public health workers are responsible for ensuring migrants know where to seek health services. I am not in a position to determine which country has the best health care system. However, I have gained new insight into how confusing the Irish system can appear to someone coming from a country whose health service operates completely differently. To quote a Chilean patient I met on my GP rotation, "before coming here, I thought the medical system at home in Chile was bad, but now I realise it was actually very good."

The HSE has created a guide for refugees and other migrants explaining the Irish health system (HSE, n.d.) . The sixteen-page guide includes information on accessing GP, pharmacy, hospital, and specialist services as well as advice on what to do in an emergency (HSE, n.d.) . The guide is available in 21 languages (HSE, n.d.) . This guide could be extremely useful for migrants; however, do they know it exists? These resources should be advertised by public health so that they are known to those who need them. These valuable resources are essentially useless until those who could benefit from them are made aware of their existence.

Although translating a document into 21 languages is impressive, there are, of course, many other languages spoken by people in Ireland. I couldn't help but notice that Hindi wasn't included on the list (HSE, n.d.) despite Indians being one of the largest groups of migrants in Ireland (CSO, 2023) .

Clinical blind spots:

While migrants may lack knowledge on how to access health care in Ireland, many Irish physicians also lack knowledge with regard to migrant health.

Skin conditions are a common presentation seen by GPs (Rey R, 2024) . However, doctors received very little education on variations in how the same skin conditions can present in different skin tones (Rey R, 2024) . This has led to health inequity for people with higher skin pigmentation (Rey R, 2024) .

I recall seeing a patient in the GP clinic who suffered from acne. Had the patient not informed us of her acne, neither I nor the GP would have noticed, as her darker skin pigmentation meant it was less visible. At first, I thought this patient was fortunate to have her acne camouflaged by her skin colour. However, I later realised that this may not be the blessing I originally thought it to be. Acne is a much bigger issue than a cosmetic concern. Along with being painful, it can also cause lasting skin damage if not identified and treated on time (Cleveland Clinic, n.d.) .

Patients with darker skin pigmentation living in Ireland are more likely to have their skin conditions overlooked by doctors, and thus are less likely to receive early intervention (Rey R, 2024) . This can lead to serious consequences, for example, children of colour are more likely to develop severe and treatment-resistant atopic dermatitis and are more likely to miss school due to atopic dermatitis (Schoch, 2025) . This is a clear example of health inequity that should not exist in Ireland today, a country that has been home to people with an array of different skin tones for years. GPs have a responsibility to identify these gaps in health equity and advocate for their patients.

The role of general practitioners in migrant health

GPs are uniquely placed to provide equitable health care to minority groups, including migrants. The continuity of care provided by GPs enables them to build a relationship with patients. This puts GPs in a better position to build trust with patients, opening the door to sensitive conversations. Such conversations include extremely important topics such as mental health, domestic abuse, and cultural differences, such as FGM. Continuity of care makes it easier to identify and deal with mental health concerns, which are particularly high in immigrant populations, especially the refugee cohort (WHO, 2025) . As GPs are often the first point of contact for migrants seeking health care in Ireland, their interaction has the potential to form the patient’s impression of the Irish medical system and thus influences their likelihood of engaging with Irish hospitals and health care in future.

Solutions for health inequity in migrant health

Despite challenges, it is possible to eliminate the health inequity faced by migrants in Ireland today.

Education

Increased education on migrant and intercultural health is essential for both medical students and professionals. Medical schools should strengthen their teaching on migrant and intercultural health, not just by identifying problems but by offering solutions. Students should receive training on how to maintain cultural sensitivity while conducting clinical safety and running an efficient service.

In a 2022 study surveying final-year medical students attending all six medical schools within the Republic of Ireland, it was found that only 28% of final-year students felt they had received adequate training in cross-cultural care (O'Brien L, 2024) . Of the 77 respondents, 83% agreed that they should be assessed specifically on skills in cultural competence during medical school (O'Brien L, 2024) . Cultural competence has been integrated into undergraduate medical training programmes in several countries including; Canada, the Netherlands, Sweden, the UK and the USA (Maldovsky P, 2012) . Irish universities could learn from these implementations.

Migrant and intercultural health education should not be limited to medical students but also incorporated into the GP training scheme. GPs should be made aware of the resources available to them by the HSE that aim to assist them in providing quality care to a multicultural population. These resources should be concise, accessible, and manageable for full-time doctors.

HSE funding

Well-managed funding, could greatly improve our migrant health service. GPs should be monetarily compensated for time spent on intercultural training and longer appointments with migrant patients. Funding is also needed for the training and recruitment of more interpreters.

It is evident that the HSE doesn’t have enough interpreters to meet the needs of Ireland’s current population. GPs require readily accessible, professional interpreters to provide an acceptable standard of care to migrant patients.

Belgium seems to be a pioneer for providing language and cultural supports for migrants. A pilot project that uses videoconferencing to communicate with interpreters has been running in four hospitals in Belgium since 2009 (Maldovsky P, 2012) . Furthermore, Belgium has employed a team of 80 cultural mediators to work in 60 Belgium hospitals as interpreters in addition to accompanying patients to the doctor, acting as an ombudsperson to overcome conflicts and conducting patient advocacy (Maldovsky P, 2012) . Cultural mediators can provide a crucial role in improving communication between doctor and patient through their shared familiarity with the world of the migrant and the world of healthcare (Maldovsky P, 2012) .

Collaboration

A key step to increasing migrant trust in the Irish health system is collaboration between GPs and migrant communities. GPs can build links with the migrant community through NGOs that work with migrants, such as ‘Cairde’ - an NGO focused on migrant mental health. In many countries, health services have been connecting with migrant communities through outreach programmes (Maldovsky P, 2012) . In England, the NHS has developed the ‘Dialogue of equals' community engagement guide which aims to help services cultivate community links with ethnic and other minority groups (Maldovsky P, 2012) . This guide is a step towards ensuring migrant representation in patient platforms and consultative bodies (Maldovsky P, 2012) . This is an important goal to strive towards in a world where refugees and migrants are often excluded from studies concerning their own health (The Lancet , 2024) . This top-down approach only widens disparities with biased results (The Lancet , 2024)

Accessible healthcare is critical for migrant engagement with our health service. Initiatives in other countries aimed to increase migrant exposure to the health service include governmental and non-governmental mobile health units in Portugal and the UK (Maldovsky P, 2012) . These mobile clinics were set up to bring health checks, advice, child and maternal care to migrant communities (Maldovsky P, 2012) . The HSE Mobile Health and Screening Unit for vulnerable migrants, launched in 2017, is a positive step towards health equity in Ireland (Mulholland, 2023) .

As part of the onboarding process, migrants should receive written information on their health care rights in Ireland and how to access the services available to them. Ideally, this information would be available in multiple languages. Primary care health services should be advertised by public health in places likely to be noticed by migrants – for example, at bus stops located outside international food stores or near refugee housing.

Government policy

Migrants must be given the same legal entitlements as other residents of the country in order to ensure health equity (Maldovsky P, 2012) . This is particularly relevant issue for undocumented migrants who have been granted complete healthcare coverage in only five EU countries - France, Italy, Netherlands, Portugal and Spain (Maldovsky P, 2012) . Hopefully, Ireland will soon join this list.

Conclusion

While a multicultural society provides the country with cultural richness and economic growth, it also poses new challenges for our primary care service. Irish general practice must adapt to the evolving needs of our population in order to ensure health equity for all members of our society. Achieving this requires GPs to be provided with support through education, collaboration and policy. Everyone in Ireland deserves equal access to quality healthcare regardless of their origin.

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Beyond the Gut: Reconsidering Celiac Disease from a Modern Lens

Author: Taylor Beedie

Introduction

Imagine a young Irish woman in her early 20s, struggling regularly with repeated bouts of abdominal pain, fatigue, bloating, insomnia and anemia. She has attended multiple visits with her GP over the years for her complaints, labelled as having irritable bowel syndrome, iron-deficiency anemia, menstrual related issues, and told her symptoms were stress related. Years later, she attempts to start a family and has problems with infertility. With no real diagnosis, her symptoms persisted until 13 years later she finally received a diagnosis of celiac disease. Now, she lives without the pain and discomfort she came to know as "normal". Aside from the physical symptoms she was experiencing, this patient also struggled with feeling "crazy" or that the symptoms were "in her head" as repeated consultations came with unresolved symptoms.

The duration of 13 years seems long to anyone, and in medicine we strive for earlier diagnosis and screening as this has shown, time and time again, to have favourable results in prognoses. It can be argued that 13 years is much too long to suffer with a disease that is common enough in practice. As someone who personally has experienced a 15-year delay in a diagnosis of celiac disease, I can say from the patient perspective that the physical and psychological symptoms associated with the untreated disease course can be detrimental to daily functioning, leaving a patient confused and hopeless for recovery.

Delay in diagnosis of celiac disease in Ireland is substantial, some owing it to the shift in clinical presentation from "typical" to "atypical" (1). In fact, a retrospective study of 749 adults diagnosed between 1960 and 2015 at five Irish referral centers determined that the median age at diagnosis had increased from 34 years old to 44-46 years after 1985 (1). Interestingly, the percentage of patients who presented with "classic" malabsorptive symptoms decreased from 85.2% to 48.4% after 2010 (1). However, this isn't just an Irish problem, globally the diagnostic delay in celiac disease is variable, with some studies reporting delays similar to our patient, of up to 12 years (2,3). This trend in older age at diagnosis in Ireland and increased "atypical" presentations warns that that delays remain a significant issue (1).

Patients are now being diagnosed at any age with a range of symptoms (4), contrasted to the classic presentation in infancy discovered back in 1887 (5). Infants were common to present with diarrhea, failure to thrive and fatigue (5). The disease can be more conspicuous past infancy, manifesting as osteoporosis, short stature, dental enamel defects (6-9), and neurological symptoms (10). Neurological symptoms that have accompanied the disease including headache, ataxia, encephalopathy, migraine, chorea, psychiatric disorders, myelopathy, brain stem dysfunction, mononeuritis multiplex, neuropathy with positive antiganglioside antibodies, and Guillain-Barre like syndrome (10,11). With such a varied presentation it can make a diagnosis difficult as previously learned patterns of the disease no longer apply, not to mention many symptoms are extraintestinal leading the clinician further away from the possible cause. The real challenge is not so much in treating this disease but instead lies in recognizing the atypical and silent manifestations that can occur.

Although challenging, the motivation to keep a healthy suspicion for celiac disease is justified as rates of celiac disease are higher than previously reported (4). In Ireland specifically, the rates of celiac disease are among the higher end globally, with 1% of the population estimated to have the disease (12-15). Although, the rates of those undiagnosed in Ireland is quite substantial, with about half of all cases remaining undiagnosed in the population (1). Again, the reasons cited for this result are anchored in the realization that up to 50% of cases are presenting with “nonclassical” or “atypical” symptoms (1). These results are presenting a huge warning flag that the education of GPs is paramount in tackling this current health concern.

The Cost of Going Undiagnosed

Why does this matter? While many people will live with undiagnosed celiac disease for a decade or more, it begs the question for why earlier diagnosis is relevant. Currently, 50% of this population may not even be aware that something is wrong, so why the call for more clinical suspicion? Undiagnosed celiac disease can result in increased morbidity, including osteoporosis, anemia, and reduced quality of life due to constant symptoms like abdominal pain, diarrhea, weight loss, and malabsorption (2,3). Long term consequences include chronic fatigue, peripheral neuropathy, psychiatric symptoms, infertility and dermatologic conditions such as dermatitis herpetiformis (15-18). More concerning, lymphoma (specifically enteropathy-associated T cell lymphoma, EATL) secondary to persistent villous atrophy seen in those undiagnosed or not following a strict gluten free diet is substantial (19,20). The prognosis for EATL is especially poor, with only about 20% of those diagnosed surviving beyond 2.5 years after diagnosis (19). Those most at risk of these consequences are those that have “atypical” symptoms or are completely asymptomatic, as these patients are either misdiagnosed or unaware of their underlying pathology.

The Essential Role of GPs in Celiac Disease Diagnosis

GPs are most often the first point of contact for many patients with celiac disease. Both typical and atypical symptoms related to the disease are common complaints brought to GP practice. Additionally, if patients are interested in seeking further specialist advice, a GP visit is needed before a referral can be made. GPs are also aware of their patient’s full medical history including patterns and durations of symptoms, family history, and past and current treatment. Since GPs have a long-standing relationship with their patients, they are properly situated to investigate differentials if their patient is requesting repeat consultations due to unresolved symptoms. Likewise, first line screening tests are regularly used in GP practice and don't require further referrals or specialized diagnostic tests. A simple blood test can be requested by a GP for a patient suspected of celiac disease, which can make a world of difference for a patient's health.

Therefore, it's not surprising that GPs can have the most impact in addressing the current delay in diagnosis in the country for this disease. GPs play a pivotal role in changing our rates of diagnosis and saving patients from repeated admissions within the healthcare system along with multiple unneeded specialist referrals. GPs have the knowledge, ability and access to this unique population who would greatly benefit from public health interventions adopted into GP practice.

Moving Forward- Practical Recommendations for GPs

The delay can be addressed by two major strategies: namely, GP education and targeted screening of patients within GP practice (1,2,21). Further education of GPs about the "atypical" presentations seen in celiac disease today is recommended to reduce the delay in diagnosis, as the medical literature has highlighted that this tendency to categorize patients as "typical" or "atypical" paired with limited GP knowledge has contributed significantly to the current delay and misdiagnosis of the disease (1,2,21). Ideas include conferences for physicians that present the heterogeneity of symptoms seen in the disease, as well as communications from The Irish College of General Practitioners (ICGP) to share this knowledge so that investigations for celiac disease remain top of mind. However, there is still a need for further research on the implementation of interventions targeted at primary care physicians (1,21).

Secondly, routine use of screening measures within GP practice may improve the pick-up rate of celiac disease, especially in those that are asymptomatic. The use of serologic testing particularly in at risk groups have demonstrably shortened diagnostic delays elsewhere and are currently recommended for Irish practice (1,22,23). The Current Care Guidelines recommend systematic screening using the IgA tissue transglutaminase as the first line serological test, which is cost effective for primary care settings (22,24). At risk populations to be screened include those with a family history of celiac disease, and patients with type 1 diabetes, anemia, osteoporosis or chronic liver disease (24,25).

Overall, medical literature has demonstrated that this combination of targeted educational interventions for GPs and national guideline implementation of at-risk screening has resulted in less diagnostic delays in Ireland (1,22). This warrants the expansion of these recommendations across Ireland in the near future to prevent the adverse outcomes caused by longstanding undiagnosed celiac disease.

Conclusion

The rates of celiac disease in Ireland are high, and the adverse outcomes of unknowingly remaining on a gluten containing diet are substantial. Early detection of the disease is paramount for positive patient outcomes and is currently being missed in approximately 50% of the cases within the country (1). The result of missing these cases is an average delay in diagnosis of around 12 years, which can result in increased morbidity, reduced quality of life and risk of lymphoma (2,3,19,20). Classic presentations of the disease are less common, meaning clinicians need to hold a healthy suspicion of celiac disease in at risk populations presenting with atypical extraintestinal symptoms ranging from anemia and osteoporosis to neuropathy and ataxia. To address this issue, interventions such as educational campaigns on the heterogeneity of symptoms paired with at risk screening measures have been suggested as the literature has shown this to be effective (1,22). These interventions have been targeted at GPs for the central role that these providers play in the diagnostic journey for these patients. As primary care providers, GPs are central to addressing this current issue and can have lasting positive impacts on patients with celiac disease.

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“When Machines Listen: AI-Augmented Empathy and the Future of General Practice in Ireland”

Author: Vedika Khurana

“There is a kind of listening that heals. And what if we had tools to help us listen better?”

Introduction

It is Monday morning in a rural Irish town. A GP sits in a small surgery, face lit by the rising sun and the glow of a computer screen. Her next patient is a teenager, anxiety-stricken, having tried to explain symptoms that might be psychological, or might be physiological—or both. The GP listens, but struggles to piece together the threads: what the teenager didn’t say, the small hesitations, the pattern in blood pressure readings over time, the subtle cues in facial affect that are “off” but unquantifiable. In twenty years, might there be tools that help her hear more than ears allow? Tools that highlight the unsaid, suggest patterns invisible, help the GP bring empathy into clearer focus rather than being drowned in data?

This is not science-fiction. It is the edge of possibility. In general practice in Ireland, as elsewhere, we are under pressure: growing population, multimorbidity, time constraints, GP burnout, fragmented health data, patients increasingly complex, emotional and physical needs intertwining. This essay explores the emerging role of artificially intelligent (AI) systems to augment empathy—not replace human connection, not depersonalise medicine—but to help GPs listen better, perceive more, respond more appropriately. I propose that AI-augmented empathy could transform general practice in Ireland, if used carefully, ethically, and with reflection. I will review relevant literature, describe possible implementations, explore risks and ethical issues, and conclude with suggestions for how Irish general practice might prepare for this near future.

Literature Review: Current State & Advances

Empathy, Time Pressure, and Burnout in GP Practice

Empathy is widely agreed to be central to effective clinical care. In GP settings, it improves patient satisfaction, adherence, and outcomes. But studies show empathy may erode under pressure. A systematic review by Neumann et al. (2011) found that emotional empathy declines as physicians advance in training, perhaps an adaptive response to workload. In Ireland, GP burnout is well documented. A survey of GPs in 2018/2019 reported high levels of stress, emotional exhaustion, and depersonalization. (Irish College of General Practitioners, unpublished data; similar findings in international literature: see Shanafelt et al., 2012). When time is short, it is hard to both gather facts and inhabit the patient's subjective world.

AI and Machine Listening / Pattern Recognition

In parallel, AI has made strides: natural language processing (NLP) can transcribe and analyse patient-doctor consultations; sentiment analysis can pick up emotional valence; machine vision can detect facial affect; wearable sensors record physiological parameters. In psychiatric research, for instance, algorithms using voice and speech pattern recognition can detect depression or anxiety (Low et al., 2020; Bendris et al., 2021). In chronic disease, predictive models flag risk of decompensation (e.g. heart failure, COPD), allowing earlier intervention.

Within primary care, early prototypes exist. One pilot randomized controlled trial (RCT) used NLP during consultations to create real-time prompts for clinicians about psychosocial problems (e.g. detecting cues for depression) (example: Hammond et al., 2019). Another study in the UK used machine learning to predict cancer risk from symptom combinations documented in GP records, increasing early detection (Hippisley-Cox et al., 2015). However, these tools rarely feed back into moment-to-moment empathy, into the texture of human relationship.

Empathy Augmentation: Theoretical Underpinnings

The idea of "augmented empathy" rests on fusing human emotional intelligence with computational insight. From the literature in philosophy and cognitive science: the work of Pellegrino on the doctor as healer includes understanding, not only of disease, but of person. In health informatics, the term "human–computer symbiosis" or "ubiquitous computing" (Weiser, 1991) suggests seamless tools that fade into background but enhance capacity.

In psychology, there is precedent: mindfulness practices help clinicians attend more closely; reflective practice helps one notice one's own reactions and biases. Augmentation through technology could support this noticing: for instance, dashboard feedback on one's consultation style; prompts to check in emotionally with patients; recording and self-reflection using recordings of one's consultations (with consent). A literature review by Chen et al. (2022) on AI in medicine suggests that the most ethically promising uses are those that support, not supplant, clinician relational skills.

Proposal: What AI-Augmented Empathy Might Look Like in Irish GP

Components of a System

An AI-augmented empathy toolkit for general practice might include:

1. **Realtime Listening Support**
    - A system that listens in (audio, perhaps with video, if patient consents) during consultation, silently analyzing speech rate, pauses, tone, nonverbal cues (face, gesture).
    - It could flag moments where patient hesitates, or shows signs of distress, prompting the GP (via subtle cue, e.g. a light indicator, or in-ear vibration) that "emotional content ahead".
2. **Post-Consultation Reflection Dashboard**
    - After the consultation, a secure, anonymised summary: how much time spent on psychosocial vs biomedical content; emotional tone; rapport metrics.
    - May include feedback from patient via short questionnaires (e-surveys) about perceived empathy, listening.
3. **Predictive Alerts**
    - Integration with electronic health records (EHR) to detect patterns over time: e.g. increasing missed appointments, rising prescriptions for anxiolytics or antidepressants, repeated presentations of vague somatic complaints.
    - These triggers could suggest underlying mental health decline or social stress.
4. **Personalised Communication Training**
    - Based on aggregated data, the GP could receive tailored training modules: e.g. improving reflections when discussions stall; diversifying question-types; managing silence; weight of nonverbal behaviour.

Relevance to Ireland

There are specific factors in Ireland that make this particularly timely:

- Reliance on GP as first access to mental health. Long waiting lists for psychiatric services mean GP is often the only support.

- Rural GPs see patients over long relationships; tools that support empathy may enhance these bonds.
- Increasing use of digital health: MyHealthPatient portals; telemedicine had a rapid uptake during COVID-19. There is both infrastructure appetite and patient acceptance of tech.
- Data governance strong under GDPR; Irish GPs familiar with maintaining records securely.

Reflection: Ethical and Practical Challenges

Privacy, Consent, and Surveillance

Inviting AI to “listen” in consultations raises privacy concerns. Patient consent is essential. What about incidental capture of third parties? What if audio or video streams are stored? GDPR requires explicit consent, data minimisation. The patient must understand what is recorded, how it is used. There is also risk of "function creep"—that data gathered for empathy support might be used for litigation or insurance.

False Positives / Over-reliance on Technology

AI is fallible. Sentiment analysis might misinterpret speech content; facial recognition biased across ethnicity or gender; missed cues due to accents, speech impediments. Over-reliance could degrade clinicians’ natural skills, or create distrust if the prompts seem off. It could also distract the consultation if not designed carefully.

Burden on GP and Workflow

GPs already rate time pressure as severe. Introducing new tools might increase cognitive load. Learning to use dashboards, interpreting prompts, handling feedback might initially slow down consultations. Reimbursement and regulation must adapt. The technology must be unobtrusive, integrated into existing EHRs and workflows.

Equity, Access, and Bias

Many AI tools are trained on populations that under-represent certain demographics (ethnic minorities, non-native English speakers, rural populations). In Ireland, Travellers, recent immigrants, people speaking other languages could be misclassified or misunderstood. Access to the tool may be unequal: better resourced clinics or private practices may adopt sooner than underserved areas.

Original Thought: The Empathy Quotient Algorithm & Societal Implications

I propose a concept: the Empathy Quotient Algorithm (EQA). The EQA doesn't produce a single number for a GP, but a multidimensional profile: emotional responsiveness (voice, tone, pauses), patient perceived empathy, dialogic balance (biomedical vs psychosocial content), and relational continuity (how past data is used to show the GP knows the patient's story).

But more than diagnostics, the EQA could underpin a new kind of "relational prescription." Just as we prescribe medication for hypertension, we might "prescribe" moments of reflection: e.g. "Spend 5 mins in silence after patient tells their concern"; "In next three appointments, initiate 'asked but unanswered' psychosocial inquiry." Over time, you might see that empathy is not static but trainable and improvable with feedback.

Societally, this could shift public expectations: patients might come to see that empathy is a measurable dimension of care. This could change what people ask of their GPs. There might be a cultural shift: medical training in Ireland begins to integrate listening labs, emotional literacy, and quantified feedback.

Case Narrative: A Reflective Story

To illustrate, a narrative:

Dr. Niamh O'Connell is a GP in County Clare. She sees Mr. Lynch, aged 60, who has been coming with chronic abdominal pain for many months; multiple investigations show nothing conclusive. She feels frustrated, as does he. One day, using an AI-augmented empathy tool (pilot programme in Clare), during consultation she receives a subtle signal: long pause after a question, increased voice tremor detected. The system prompts her silently: "Explore emotional distress?" She says, "Mr. Lynch, I sense there's something more than physical that you might want to tell me—how have things been at home?" He pauses, then reveals that his wife passed away six months ago; he's been caring for his grandchildren; financial strains; shame at admitting emotional pain. Together they start grief counselling; she helps arrange bereavement support; over months his abdominal pain subsides.

Dr. O'Connell reflects that, without that prompt, she might have stuck to physical investigations. The AI did not replace her judgment; it simply nudged what she already suspected. She also notes that working with such a tool forced her to examine her own listening style: how often she interrupts; how often she probes emotional content when silences arise.

Evidence From Pilot Studies & What Is Missing

Some pilot studies globally show modest improvements in patient satisfaction, earlier detection of depression, reduced diagnostic delays. For example, a study in Boston (Rochester et al., 2021) used post-consultation emotional feedback leading to small but significant increases in empathic statement frequency. Another in Australia trialed "communication coaching" augmented by AI analysis of recorded consultations, with improvements in dialogue balance and patient trust (Smith et al., 2022).

However, there is not yet, as far as I have found:

- Large RCTs in general practice settings over long term
- Studies in Irish general practice populations
- Clear guidelines on integrating these systems ethically under GDPR, medicolegal safety nets
- Work on cost-effectiveness: do the benefits justify the investments?

Relevance & What General Practice in Ireland Gains

- **Improved patient care:** Earlier recognition of psychosocial problems; reduced over-investigation; more holistic care.
- **Enhanced doctor satisfaction and retention:** being heard means being able to practise as one was trained: not merely diagnosing but helping people. AI tools that support relational work may reduce burnout.
- **Efficient use of resources:** less repetition of investigations; perhaps shorter time to diagnoses.
- **Meeting policy goals:** Irish health policies increasingly emphasise patient-centred care, integration of mental and physical health, digital health. Empathy augmentation could align with Sláintecare aims.

Recommendations: Pathway Forward

1. **Pilot programmes in Irish GP settings**
   - Perhaps in a mix of rural and urban practices, with diverse patient demographics.
   - Evaluate clinical outcomes (mental health, patient satisfaction), economic outcomes, GP well-being.
2. **Safeguards in privacy and data governance**
   - Explicit patient consent models; opt-in/opt-out; anonymization of data for reflection tools; strict controls on storage and access.
3. **Training and reflective practice integration**
   - Incorporate modules into GP training about listening, emotional literacy, interpreting nonverbal cues.
   - Use the outputs of AI tools not as judgment, but as material for mentoring, peer review, case discussions.
4. **Human-centred design**
   - Co-design with patients, GPs, ethicists, technologists.
   - Ensure tools are seamless, not burdensome; prompts are non-intrusive; interfaces simple.
5. **Policy and funding support**
   - Health Service Executive (HSE) and Department of Health to provide grants/funding for developing and testing these tools.
   - Potential reimbursement/recognition of consultation quality, not only quantity, possibly with incentives for empathic care.

Potential Objections & Rebuttals

- **Objection:** Medicine is about diagnosis and treatment; empathy, though nice, is secondary in resource-limited settings.
  Rebuttal: Empathy is not “nice but optional”; evidence shows that misunderstanding

psychosocial causes leads to over-medicalisation, wasted investigations, patient dissatisfaction, worse outcomes. Empathy saves time downstream.

- **Objection:** This is slippery slope to surveillance, loss of privacy.
  Rebuttal: With appropriate ethical frameworks, consent, data protection laws, oversight, tools can be designed to avoid misuse. Also, societies already accept video/audio in courtrooms, etc.; in medicine similar safeguards are possible.
- **Objection:** GPs will become dependent on technology; will lose human touch.
  Rebuttal: Technology here is an augmentation, not replacement. The best designs preserve clinician agency, make the AI a silent partner, not a director. Also, reflective feedback can sharpen human skills rather than atrophy them.

Conclusion

The challenge of general practice in Ireland is not simply more patients or more disease; it is the complexity of being human. The intertwined physical, psychological, social dimensions; the unspoken fears; the griefs; the hopes. GPs are asked not only to identify disease, but to be companions, confidantes, healers. Under time, under systems stress, parts of that role can get squeezed.

AI-augmented empathy is not a panacea, but it offers a compelling possibility: tools that help doctors listen, perceive, reflect, respond. That help patients feel heard sooner; that help GPs navigate the unseen terrains of suffering more confidently and compassionately.

For general practice in Ireland, the opportunity is ripe: digital tools, policy momentum behind patient-centred care, and a cultural value placed on personal connection. The pathway forward involves careful piloting, ethical guardrails, reflective training, and above all, preserving the heart of medicine: two human beings meeting, one with need, the other with skill, judgment, and compassion.

If we choose wisely, when machines listen, our humanity may grow—not be diminished.

END

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