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INQUIRY INTO VETERINARY WORKFORCE SHORTAGE IN NEW SOUTH WALES

Name: Name suppressed

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Partially Confidential

Since I graduated less than a decade ago, I've read and heard a lot about the shortage of veterinarians—not just in New South Wales, but worldwide. The main reasons given tend to be factors such as poor pay, euthanasia, difficult clients, long hours and parenting responsibilities. However, when I talk to friends and former classmates who are struggling in the industry or have already left it, they overwhelmingly cite poor workplace culture.

The following is an account of my own experience as a veterinary graduate in general practice. It's fairly representative of a lot of the things that other people I know were also experiencing, and I think it may help those outside the profession to understand what happens within it.

Chapter One

Rose-tinted glasses have always been my downfall.

When I received the news that I'd been successful in my application for a graduate position at a clinic for small animals, I was incredibly pleased. I had been offered another job and had been on track to receive yet another offer, but those particular clinics had left me with the impression that I wouldn't have the opportunity to learn some best-practice procedures (such as nerve blocks for dental work), and I was eager to acquire as much knowledge as possible. To be honest, I didn't think I knew anything yet, and I wondered how five full-time years had left me feeling just about as useless as when I'd first embarked on the degree program. The other clinics had strongly hinted that I might be expected to take sole charge within my first year, and I didn't feel comfortable with the idea of inflicting my inexperience on patients without someone to back me up. This being the case, I was happy to accept a reduced salary in exchange for a good learning experience, especially as everyone at the interview had reacted so positively to my answers to their questions.

The practice was run by two veterinarians who had bought the clinic a few years earlier. Some of the hints that were later dropped led me to infer that this was due to a falling-out with the boss at their previous clinic, although I wasn't sure about any of the details. To maintain anonymity, I'll refer to them as Jane and Michael. After all, a veterinary graduate encounters many situations in which the resources of Mary Poppins would be greatly appreciated, and managing wayward children has a lot in common with managing colleagues' expectations.

Following advice from other new graduates, I decided to present myself at the clinic before my official start date to learn how to use the practice software. According to my friends in the year above, this is a huge challenge to learn on the run while coming to terms with everything else that is thrown at you in a first job. After finishing the administrative tasks (like providing my tax file number), I asked if someone could show me how it worked. The person on reception that day assured me that there was no point in trying to learn before starting. It was such an intricate

program, with so many steps involved to perform even the most basic tasks, that it would be too difficult to remember anything until I actually started using it. Though sceptical, I was prepared to accept this explanation. “It’s better this way!” I told myself. “They accept that this will be a part of the learning process for you and will cut you some slack while you figure it out.”

Ha. Ha. Ha.

Once I’d spent a few days shadowing a couple of other clinicians, I was left to manage “simple” consultations on my own. There was no real induction, and I spent most of my shadowing period trying to understand what was happening with the patients. The software being used required several steps for every task, so I only made it as far as being able to bring up some basic templates to be able to write up my consultations. Jane's frustration at my inability to charge for procedures drove her to sit me down and go through a couple of examples with her. I was glad to be taught this skill at last, but this joy was greatly tempered by the general impatience that accompanied the exercise, as though I still couldn’t manage something I’d been shown countless times before (I hadn’t). When I didn’t remember all the steps after being shown once, she interrupted the exercise with a tirade.

“Do I make you nervous?" she suddenly snapped, catching me off guard. "Because you seem to me to have a bad memory. You’ve been here almost a month. I’m not part of the computer generation like you are and I learned how to use this program in two weeks. I want to know why you’re having so much trouble with it.”

This would have been easy enough to respond to: I was in a completely new workplace; I was simultaneously learning how to approach the medical and surgical aspects of the job, leaving less mental bandwidth to devote to a computer program with multiple steps to achieve each individual outcome; I was not yet familiar with the way the practice charged for the various types of procedures; the veterinarians I was shadowing when I first arrived had been too pressed for time to explain what they were doing on the computer during their consultations… Also, if she was going to talk about memory, I could have pointed out to her that she couldn’t even get my name right for the first two weeks I was there, even though I was the only new starter. (Assume that my name was Jennifer, and she kept calling me Jessica.)

Utilising the pause that followed her last sentence, I took a second to recover from the shock at being addressed so rudely and began to form my response. However, I hadn’t managed to utter more than two words before I was abruptly cut off. “I don’t want to hear excuses,” she snapped. It seemed that wanting to know didn’t actually mean wanting to know.

It was probably just as well that I had a bad cold at the time, because a healthier version of me might have had the presence of mind to fully appreciate how wrong the situation was. As it was, I was content to be concealed within my illness-induced brain fog until I could shake her off again.

On some points, Jane even made her dissatisfaction clear pre-emptively, bringing up things I hadn't even had the opportunity to fail at yet. For example, she sternly declared that she expected me to be able to process an EFTPOS payment. Given that I had not received any training in processing payments, which certainly hadn't been covered in any of my units of study at university, I wasn't sure why it seemed to be viewed as a terrible failing on my part not to possess this skill already. Did they assume that everyone had worked in retail?

Employing the same tone of attack, she told me that that I should have been taking the opportunity to practise charging for Michael's procedures when I was rostered on to shadow him while he was performing dental work, instead of standing around watching. Any reasonable onlooker would have been given the impression that such a request had been made of me 100 times and I'd wilfully ignored it, when in reality the issue had never been raised by Michael, who would probably have been highly irritated if I'd interfered with his payment template. Moreover, given that the intricacies of charging for procedures using the practice software had not been demonstrated to me, it certainly didn't occur to me to ask again. I would have jumped at the chance to spend the time learning how to charge for procedures on those occasions, or to do anything useful, really, because standing around watching had made me feel like a redundant nuisance.

Of course, it would have been far preferable for me to have spent the time learning how to perform the procedures themselves; observation without explanation can only get you so far. I understood that many of these patients had serious dental problems or underlying medical conditions that meant they needed to be attended to by someone experienced and quick, but I was sure there were components of the procedure that I might have been able to start practising in preparation for my own cases. I made no secret of my enthusiasm for learning nerve blocks, but I would be lucky even to witness one, and I certainly wasn't given the opportunity to perform one. I didn't complain, reasoning that I was still too new to be making demands, and I believed that my turn would come one day. I knew from discussions on my year group's Facebook page that several classmates were already performing nerve blocks, usually under supervision at this early stage, but they were the primary clinicians all the same.

(Eventually, after several months, Jane discovered that I had not yet performed any nerve blocks under her business partner's supervision and, astonishingly, allowed me to perform one on a patient of hers. Unfortunately, a single nerve block in four months spent at a practice renowned for its high dentistry caseload did not leave me confident that I could skilfully reproduce the procedure on my own.)

It was difficult to tell whether I wasn't being trained to manage certain cases because there simply wasn't the staffing capacity to mentor an inexperienced new graduate or because I came across as innately incapable. The latter conclusion was a lot more consistent with how I'd felt about my skills before starting the job, so it quickly became my reality. I started to truly believe that there was something about me that meant it would be impossible to learn even if they were inclined to teach me. Perhaps my bosses were concerned I might otherwise be overwhelmed

when they gave a directive to the receptionist and nurses to book only “simple” consultations in with me (this being clearly displayed in bold capitals at the top of my consulting column in the scheduler from the time I started).

Of course, whether something is simple is relative; just about anything can be challenging if you’re encountering it for the first time. If there was an emergency case or a scheduled complex procedure, such as a non-routine surgical case or dental work requiring extractions, my role was to take over the experienced veterinarians’ routine procedures, such as vaccinations, to allow them to focus on the important work of managing this complexity. This made sense in terms of efficiency, because there would have been a huge delay at the clients’ end if I hadn’t been there to move the routine cases through. It was also a state of affairs that would have given me far more peace of mind had I been the client, because nobody wants the useless new starter to be making life-or-death decisions for a loved one.

However, the obvious result was that I was not acquiring the necessary experience under direction to eventually manage non-routine cases on my own. Even things I had actually seen or done at university were fading into a distant memory. Meanwhile, everything I hadn't had the chance to see at university was purely theoretical, and I couldn't picture myself going through the steps of dealing with it. For example, I knew from my lectures that something called N-acetylcysteine was used to treat a paracetamol overdose, but I wouldn’t have known anything about what it looked like on the shelf or how to go about administering it. The information was simply words on a page to me. While people who have encountered a situation before can replay the past experiences mentally in order to appreciate which steps to take next, my mind would have drawn a total blank, or (at best) a recollection of the background colour in my lecturer's slides when that topic had been touched on several years earlier.

What I did manage to see of emergency management at the clinic was the occasional glimpse of a bottle or fluid bag while passing through the treatment room between episodes of reassuring the waiting client or picking up the next consultation. Although I rather enjoyed the client contact, the lack of continuity meant that I didn’t understand how to approach the thinking process behind emergency management. This wouldn’t have been such a problem on its own at that early stage if I hadn’t felt that there was an expectation (real or imagined) that I ought to be developing such an understanding, and it was this expectation that was causing me anxiety.

Another thing that made learning new skills a challenge was that after a few weeks, most of the other clinicians were no longer open to the idea of having me observe their consultations when I had time to spare at the end of my surgery list, usually telling me they were too tired and stressed to have another person around. I could completely understand that they did not want an overly enthusiastic new graduate buzzing around them during their consultations, pressing them to answer questions and explain their clinical reasoning in the brief gaps before the next consultation, so this made sense. I felt that the more I sensed that I wasn’t good enough for practice, the more eagerly annoying I became in my desperation to find out how to do things differently, and this was exhausting for everyone. They were trying to get through their

consultations quickly and go home on time. Even in the best cases, a new graduate represents a big imposition on the time and mental resources of other people at the clinic. And I knew that I wasn't one of the best cases.

Chapter Two

Everything I did at the clinic, especially in my first month, made me feel like a walking disaster. I accidentally vaccinated a table with a subcutaneous rabbit vaccine that was in short supply (my term for inadvertently pushing the needle straight through the skin fold and out the other side, necessitating a second attempt); I failed to add a heartworm injection to an invoice; I put tropicamide instead of tetracaine into an eye I was about to examine, thanks to the identical-looking vials in the same location in the fridge, which meant that I had to advise the client to keep the patient away from the light for the next few hours... I wondered how I could possibly be so bad at everything. I remembered that at the university clinics my friends and I could answer about as many questions as each other (though not necessarily the same ones) and did just as well in the assessment tasks, but there was no way that anyone could have convinced me that our performance at work was similar. I imagined that they were managing everything without trouble, except for the problems caused by circumstances beyond their control.

Just after starting at the clinic, I was in the room while another clinician was managing an induction that wasn't going well, and I was eager to feel useful by drawing up some more of the induction agent alfaxalone as required. The nurse mentioned that I'd reached for the acepromazine instead, so I quickly switched the bottle for the correct one. Then, thanks to my moronic upside-down reading of the syringe, I drew up 1 ml less than requested; the clinician pointed this out and I drew up extra before handing it to her. Of course, I felt like a complete idiot, because I'd been so eager to show that I could be helpful. I still tried to talk myself out of dwelling on the situation to the point at which I'd be paralysed with a fear of failure. A report of this incident was apparently given to Jane, because eventually she asked to speak to me about it. I was told that it was irresponsible of me to come to work when I was too unwell with a cold to function without codeine (which I had taken because my colleagues made it clear that they were bothered by my persistent coughing, rather than due to any feelings of malaise), because this was causing me to get drugs and doses wrong (both used in the plural), creating a dangerous situation. I personally don't blame the codeine or my illness for this; it was purely a matter of my being stupid in my overzealousness. Of course, I was already actively fighting my natural tendency to dwell on it, so I didn't know what she was trying to achieve. Did she think I'd done it deliberately, just for fun, and that I would now make a conscious decision to stop only thanks to her? I'd like to have said that creating a situation whereby employees don't feel they can take time off when they have a cold isn't entirely helpful, either.

What I didn't mention at this discussion was that in the week in which this incident had taken place, I'd also prevented Michael from drawing up the wrong drug in a similarly fast-paced situation, when he'd reached for the wrong bottle from the two that were available during a diazepam-ketamine induction. I viewed this as evidence of successful teamwork, rather than a failing of any particular individual, so I didn't think anything of it at the time. On this occasion, Michael had been using a slightly less mainstream induction protocol, but certainly one he had used before, so all the vials were familiar. Did the nurse report to anyone else that I had

prevented someone from drawing up the wrong drug? If so, I never heard about it. Some time later the same nurse casually mentioned that this was not an uncommon occurrence with him, and that she and the other nurses frequently had to call him out. It was not said with any malice; it was more like an affectionate acknowledgement that muddle-headed clinicians would be lost without the assistance of practical nurses. Again, this was evidence that the system was working, because, thanks to the nurses (and to me on that one occasion) he wasn't administering the incorrect drug or dose. Why, then, was this a sign of my particular ineptitude relative to everyone else's? My sense of self-hatred was beginning to experience weak competition from a slight consciousness of injustice.

On another occasion, when I was asking a different nurse to teach me her bandaging technique (something my year group hadn't really covered in the degree program but which I was keen to master all the same), she affectionately remarked that Michael was hopeless at bandaging, usually having to rely on the nurses. He was also notorious for his failure to enter his S8 drugs into the book, sometimes falling behind by a couple of days if his colleagues didn't remind him or, in the case of veterinarians (including me on a couple of occasions), record the drugs ourselves if we'd seen him use them.

It occurred to me that this may be an example of the different expectations faced by women and men in the industry, which I'd already observed at other clinics as a student. A male veterinarian with scatterbrain tendencies appears to be regarded as a kind of savant, considered to have superior clinical expertise – something of a "mad scientist", perhaps. Poor organisational skills and illegible handwriting are almost prerequisites. After all, a genius who is preoccupied with solving important problems should not be expected to do the job of a receptionist, a nurse or a kennel hand, which is why people with complementary skills are employed to do that work for them. Conversely, it seems that women are considered to be completely unsuitable for any cerebral tasks if they are not supremely competent at the administrative and practical jobs first. For example, they must be exceptional at bandaging, answering the phones and tidying up after themselves. These are all useful tasks, of course, but they add up, meaning that someone who is not expected to perform them well eventually has more time and mental capacity for their veterinary work.

Staff members at the clinic appeared to anoint other staff members as either good or bad at an early stage, and the relative merits of whatever they had done would be determined as positive or negative depending on which of the categories they had already fallen into, rather than whether the action itself was good or bad. This phenomenon is common among humans, of course, and hardly confined to workplaces. Is it the ad hominem logical fallacy? The anchoring bias? I'm not sure, but it's acknowledged to be highly damaging. I once watched a documentary on SBS (*Every Family's Nightmare*) that compared different approaches to investigating a crime: the nominative and eliminative approaches. While the eliminative approach is based on investigating a large pool of potential suspects and using the findings of the investigation to eliminate them, the nominative approach is based on selecting a suspect and building a case around them. According to the documentary, the latter is considered to be a poor approach to

investigation by the world's more respectable police forces, because the tendency is to try to make the evidence fit when it doesn't.

Office politics can function as a real-life application of such an approach, and your life can be miserable when you begin to sense that you've been "nominated". I noticed that other clinicians could get away with making similar or worse mistakes while maintaining a "good bloke" reputation that made everybody (even me) admire them nevertheless. Perhaps this came from appearing relaxed, which I definitely didn't. (In fact, I was becoming tenser with every passing day, and my abysmal acting skills would not have helped me to conceal this.) They were also gushing in their praise of a new nurse (let's call her Pansy) who had started work shortly before I had, and made every effort to frame whatever she did as being driven by the noblest and most sensible motives, even when she was actively working to undermine me when I had made reasonable decisions that led to positive outcomes. It seemed that a dark cloud was hanging over everything I did, sapping any feeling of satisfaction I may have derived from small successes that would otherwise have served to keep me motivated.

My status as a second-class staff member was reinforced too many times to count. A few months into my time at the clinic, we received a visit from a client who clearly had more issues than I could fathom. She was accompanied by a dog who, while energetic and obviously fond of his human companion (and everyone else), was terrifyingly thin and had an ominous-looking lump that had ruptured into an open wound. The story of how she'd acquired her pet (he'd jumped into her car while she was visiting the beach) also sounded suspicious, though she related it to the receptionist with something resembling pride. It was obvious the client had no idea that things were not quite as they should be, and I realised I could use this lack of insight to elicit honest answers about the dog's history. This is something very difficult to achieve in many veterinary consultations, given the tendency of some clients to bend the truth somewhat to avoid looking bad: the lump that has been present for weeks was "noticed this morning"; the food that contributed to a pancreatitis flare-up might possibly have been table scraps offered "by the children"; the frequency of walks is rounded up for good measure; there is absolutely no chance the dog could have had access to hash cookies, unless the housemates or neighbours provided them.

While this dog was gratefully inhaling the bowl of food I'd placed in front of him to assess his appetite, the first part of the consultation went as planned. I was friendly towards the client, and made sure that the deep concern I had about the situation didn't come across as judgement when I asked my own questions or responded to hers. Despite my misgivings, I realised she was a well-meaning person who was trying her best to take care of a creature she thought she'd rescued from the streets as a collarless stray – a task completely beyond her when she barely had the wherewithal to take care of herself. She opened up very easily and was quite unguarded in her responses until one of my colleagues (henceforth to be known as Kim) burst into the room and interrupted the consultation to express horror at the dog's emaciated condition, demanding to know why he wasn't being fed enough and attacking the client's line of reasoning when she responded.

Eventually, Kim deigned to glance in my direction and I was able to give her a subtle signal that I had things under control. Of course, I wasn't going to snap at her to leave while the client was present, but it grated on me that she was interfering with my history-taking strategy without discussing it with me first. Though the interaction had been short, Kim's demeanour was clearly affecting the client. It was dawning on the latter that we might be judging her based on what she was telling us, and her formerly open answers were becoming evasive. Thankfully, by that time I already had most of the information I needed.

Although I was still preoccupied with the consultation, it was impossible to ignore the glaringly obvious fact that Kim did not respect me as a colleague. It was a certainty that she would have had a complete meltdown if I'd done the same thing in one of her consultations (most likely not even waiting until the client was out of earshot to make those feelings known). At that point, she hadn't even wanted me observing her consultations, finding my mere presence too much of an inconvenience. I could have understood if she'd knocked on the door and asked to speak to me quickly in the hallway to draw my attention to something I may not have noticed, permitting me the benefit of her years of experience. However, any idiot could have seen from the opposite side of the suburb that this dog was far too thin, and I hoped that I was least as observant as any idiot. Apparently Kim didn't think so.

The outcome in this case was a good one for the dog, who was reunited with his original humans after the woman agreed to surrender him to the clinic and the second microchip scanner picked up a number that had been missed by the first (although we still had make several calls to vet clinics in the holiday town to find current contact details). I barely thought about the incident afterwards, and even forgot about it until months later. The feeling of being seen as an inferior staff member was something to which I was now so accustomed that it was gradually moving out of my consciousness into a familiar undercurrent of unease that I would have had trouble articulating. Indeed, I suspect I would have been highly suspicious and uncomfortable if my colleagues had suddenly starting treating me respectfully.

Strangely enough, this was an occasion on which I actually agreed with Jane's assessment, overheard in a discussion between her and the nurses during which she was informed about the incident later (while I was in surgery in the adjacent room). The nurses were appalled that the client could have neglected the dog's care to such an extent, with some saying we should probably have reported her, but Jane countered that it was important not to rush to attack such people, because the fear of being judged might deter them from seeking help for the patients. She didn't know how I'd managed the case, and I guess that she wouldn't have expressed those sentiments so openly if she'd known I shared them.

Chapter Three

Another red flag appeared when I asked Jane for advice on how to broach the subject of the legislative requirements when discussing desexing with a client. She swiftly cut me off with an assertion that desexing was not a legal requirement in this jurisdiction, and that entire animals merely attracted a higher registration fee. I was puzzled, as I had previously volunteered with the RSPCA in this city, and a requirement had been mentioned on a number of occasions. I also had friends who had moved from interstate and complained that they were now required to desex their dog (to my great relief). Despite these indications to the contrary, I was prepared to accept that we had all been misguided after all, so that evening I looked for the relevant legislation on the AustLII website. It took very little time to find and was unequivocal: dogs and cats had to be desexed unless the registered owner applied for an exemption (e.g. in the case of registered breeders). Of course, I didn't mention this to Jane, because I knew it wouldn't have gone down well. I'd already worked out that open communication ran contrary to the values of this practice.

That Jane was not aware of the legislation was not the thing that concerned me, as veterinarians are not lawyers, and it's difficult to keep track of everything that changes. What concerned me was that she was unable to have a discussion about the mere possibility that things were not as as she supposed without biting my head off. The fact that staff communication was poor was confirmed many times over. For example, Jane and Michael had different policies on how to dispose of the used microscope slides, which meant that I had to keep track of who had said what if either of them was present when I had to dispose of one myself, over and above thinking about the significance of what I had seen on the slide. (The one positive of this was the time when I knew where I would find an as-yet-unviewed slide that Michael had thrown out without asking me while I was wrapping up the consultation.)

In my second week at the clinic, Jane berated me for having administered an intranasal kennel cough vaccine in one of the consultation rooms. "I never want to see you give an intranasal vaccine in front of a client," she chided, in a tone that indicated I had done something wantonly reckless that contravened practice policy. It turns out that certain compromised people can be adversely affected by the droplets of vaccine that are invariably blown out by the patients. The clinicians at the university hospital and at my final-year placements had never been concerned about this, as they had always expected us to administer the vaccine in the presence of clients, but that evening I did some research and found evidence that supported Jane's view. Subsequent vaccination appointments took a lot longer now that I had to take my reluctant canine patients (some of whom weighed more than I did and were more than capable of pulling me in the opposite direction) outside to the treatment room and find an available nurse to hold them while I squirted the liquid up their nostrils, but I was prepared to accept that it was clinic policy all the same.

After I had been doing this for several months, there was one incident in which a client, left to his own devices while I was wrestling with his two large dogs outside, took it upon himself to go out to reception and pay for the consultation, even though I had not yet charged everything up. I didn't know about this until a discussion with the confused receptionist revealed that the vaccines and heartworm injections hadn't been invoiced. Michael wanted to know why I had been out in the treatment room with the dogs while this was happening. “Is it because you don’t feel confident giving the intranasal vaccine in front of the clients?” he asked, in a tone that struck me as being tinged with condescension, coming as it did after several other instances in which he had questioned my clinical skills. I could hardly believe what I was hearing. I’d been prepared to comply with this cumbersome directive because I thought it was practice policy, but it turned out that it only applied to me. All the while, my colleagues had probably been shaking their heads over what they perceived to be further evidence of my general incompetence every time I insisted on administering an intranasal vaccine away from a client.

Perhaps I shouldn’t have been surprised by the mixed messages, given what I had already experienced. A week or two after I started work, I caught the first of two successive colds, probably due to the sudden exposure to an array of colleagues and clients after weeks spent studying alone for an international accreditation exam. The onset of the second cold caused me to sneeze dramatically at the beginning of the working week, so once my procedures had finished for the day (only possible thanks to surgical masks to avoid sneezing into a patient's abdominal cavity), I thought it would be worth asking Michael (Jane was not rostered on that day) if I could leave a couple of hours earlier to buy some medication. It was my way of saying that I was going home early to respond to my body's persistent demands for time to recover, and in truth, I was expecting that he would encourage me to stay away on the following day as well; the relentless sneezing in the presence of clients was a bad look for the clinic. There was no way I would be able to respectably communicate instructions in that state, and Michael had spent enough of the day with me to be all too aware of this.

His response, though, was to encourage me to go out to buy medication immediately so I could be back in time to help out during the busy period later in the day. He was making it clear that he didn’t approve of my plan to go home and stay home, and I would be seen as a poor team player if I left before the busy period in the afternoon. This compromise suggestion was less than ideal: the nearest pharmacy was a 20-minute walk away, meaning that a round trip would put additional strain on a respiratory system that was already struggling, whereas dropping in on the way home would have required very little extra effort. I considered waiting until I left work after all, but then changed my mind; I really did need additional symptom relief if I was going to make it through the rest of the day. The problem with a cold is that it’s not as serious as something like gastroenteritis or the flu, both of which are dramatic enough to result in a clear-cut decision to stay away from work, but it’s still an exhausting and uncomfortable illness that can keep a sufferer down for a while. And longer still if you try to work through it.

The sneezing and general malaise continued throughout Tuesday and Wednesday, but I knew I had to keep going. After all, under Michael’s watch I’d continued consulting when the first cold

had completely robbed me of my voice, resulting in consultations carried out in strained whispers (a highly unpleasant situation for a new employee trying to coming across to clients as professional). Colleagues who heard my violent sneezing would repeatedly ask me if I had seen a doctor. I explained that I hadn't because it was a viral disease that would resolve on its own eventually, and that there was nothing a doctor could do to hasten my recovery. I would like to have snapped back that what I really needed was rest, rather than another opportunity for human contact, but I remained diplomatic. However, just to keep everyone happy and prove that I was amenable to all suggestions, I paid an expensive visit to a local non-bulk-billing doctor who still had appointments available. She told me the disease was viral and that there was nothing she could do to hasten my recovery. Funny that. She did, however, give me a blood test referral for good measure, so it wasn't a total loss. I felt terrible for secretly hoping the blood test result would reveal something worth investigating, just so I'd have a concrete reason for my suboptimal performance at work and a tangible excuse to take a sick day, but it transpired that I was very healthy on paper.

On Thursday, Jane returned to the clinic. When she was informed that two nurses had called in sick that day, and noticed that I also had an obvious respiratory infection, she pointed the finger squarely at me. "This is why you shouldn't come to work when you're sick!" she berated me. Given that I'd had a request to leave early denied three days earlier, when I was visibly sicker (by Thursday I no longer looked quite as bad), I did not welcome this outburst of public shaming. I was particularly annoyed that she had chosen to deliver her denunciation in the presence of the nurses. Vets are lost without the help of nurses, and new graduates are especially reliant on them. When a principal vet makes it clear to the nurses that she doesn't back a new employee, this leads to diminished respect and a reduced willingness to provide assistance when necessary. I experienced this on several occasions when clinical decisions I was happy with, and that would result in good outcomes, were openly questioned by nurses in front of clients. In an attempt to avoid demonstrating the same poor form myself, I waited until Jane was alone to let her know what the real situation was: that "another vet" had refused my request to go home three days earlier, and that although it was possible this vet had not properly understood the way in which I was framing my request, I had clearly been unwell at the time. Her reaction was not entirely what I had been hoping for: rather than a promise to be less rash and tactless in the future, there was a demand to know which vet had refused my leave request.

I knew I was never going to win this one, no matter what I did. Pointing out that I was receiving mixed messages would require me to name names and throw somebody else under the bus, something I wanted to avoid as a new member of the team. At least my naming Michael as the vet responsible was unlikely to result in problems for him, as he was another principal and apparently liked by everyone else. After some consideration, Jane reluctantly responded to this information with an admission that more consistency was required.

The mixed messages may have been a response to the difficult situation in which the principals were placed. Veterinary clinics are unlike general office environments in that an absent employee needs to be replaced at short notice—probably by an expensive locum—or an entire

column of appointments or procedures must be cancelled or rearranged somehow. The principals probably knew from staff wellbeing talks at conferences (and perhaps even from common sense, though I was learning not to credit them with too much of that) how important it is for employees to take time off when they're unwell, and that any responsible manager should make an allowance for that. However, on a practical level, this creates numerous administrative headaches, particularly if more than one employee is absent on a given day, as is not uncommon when a contagious disease is responsible and people work in close proximity. Heck, we practically have to hug each other to restrain some of our patients. Therefore, they seemed to have worked out a compromise of tacitly encouraging unwell employees to be present while openly reprimanding them for it, thereby outwardly ticking the "responsible boss" box, or at least the "not our fault" box.

The mixed messages continued, and pervaded every aspect of my work. Double ligation of blood vessels was another point of contention. One of the other vets at the practice, Veronica, told me it was a good added security measure for new graduates during surgery, and mentioned that if there was a complication, it could be difficult to defend yourself in a legal sense if you haven't placed two ligatures. She was experienced and still did it. This seemed reasonable enough, although the tradeoff was a longer anaesthesia time, and new-graduate surgeries are already notoriously long. Another of the vets, Freya, told me that she didn't double ligate because she used a modified Miller's knot, which she told me was more secure than a square knot or surgeon's knot. I had heard about this knot at a final-year placement, and at the time I'd found a journal article that appeared to confirm the greater security it offered. Freya was willing to teach me the knot, and I collected used suture material so I could perfect it in my free time. She had previously created a step-by-step document and saved it to the practice's shared computer drive to teach her colleagues, but I was the first one to express an interest. Thenceforth, I used both the more secure knot and double ligation.

Some time later, when Michael discovered that I'd been double ligating, his response was discouraging. He declared that it was unnecessary to add a second ligature if the first one was secure enough, his tone implying that he thought I wasn't bothering to ligate securely. This was obviously not the case. I was merely trying to give myself a safety net to minimise the risks, which I thought was entirely reasonable. Despite the longer surgery times, I'm quite sure that double ligation prevented complications on a couple of occasions. It was disappointing to find that safety nets were taken to be evidence of ineptitude rather than caution.

Chapter Four

The next red flag appeared when a new part-time worker (whom I'll call Laura) did a work trial to cover some general nursing and reception duties on busy days. Laura had previously worked as a vet nurse interstate and was looking to ease herself back into the workforce with a couple of shifts a week while caring for her young child. She was eager to fit in and would make small talk while working, something that could be slightly distracting at times, but nothing that genuinely hindered productivity. I could tell that her people-pleasing efforts had been in vain when I heard grumbles of complaint from the others—that Laura had accepted a failed card payment without realising it hadn't gone through, for example. I assumed this was because she was still learning, but while in the office I overheard a phone conversation Jane was having about her, presumably with the recruitment agency. She bluntly asserted that Laura was "completely unsuitable" and couldn't cope with the fast pace of the environment. She also made a reference to her "Asperger's". I was shocked to overhear this last point. If this was a genuine diagnosis that had been made, was it appropriate for her to be discussing someone else's medical history so flippantly? And if it wasn't a diagnosed condition, was she really in a position to make that call? Moreover, people on the autism spectrum can be fantastic employees if they're in the right role, so I was disappointed to hear the term used in such a strongly pejorative sense.

Perhaps the work was overwhelming for Laura, but it's always going to be overwhelming at first, and it was a busy clinic. That was the reason they'd needed a new all-rounder, i.e. a nurse who could perform some reception duties, in the first place. If her induction protocol had been anything like mine (essentially absent), I would have been very surprised if she'd been able to handle everything as quickly as our employers expected her to. Laura's propensity for verbal diarrhoea came across as the nervousness of a socially awkward schoolgirl who was desperate to fit in while being frozen out by the established cliques of cool kids, a feeling I knew all too well. I could see how hard she was trying. Whatever her faults, she was truly a nice person, and even if she was a bad fit for a particular job (something that should have reflected well on her in this case), there were polite ways to explain this to the recruiter and leave it at that. The very personal attacks were of the type I would expect if an employee had shown up to work drunk or had deliberately refused to perform assigned tasks. This was very much the opposite of the overeagerness Laura was demonstrating.

At a previous clinical placement (one of my favourite clinics) I'd been told that it's generally preferable to hire on personality; skills can be taught, but a toxic personality—even if attached to someone technically very competent—will ultimately create more staffing problems than it solves. Laura was friendly and enthusiastic, and I saw no reason why she would not have picked up the work if given genuine support, but even if she hadn't, it seemed totally unnecessary to sabotage her chances of finding another position by giving the impression that she was far worse than she really was. Jane didn't seem to have a single positive thing to say about this person, whereas I could have thought of several things without any difficulty. It made me worry about my own future employment prospects if I chose to remain in practice. What would end up being exaggerated or fabricated about me? Would all the effort I was putting in,

and all the small successes that had cost me so much energy, be completely overlooked in my employers' determination to convey exclusively negative messages about me to our shared colleagues in the wider profession?

This was just one indication of a gossip culture that hadn't been apparent to me at the interview but which didn't take long to introduce itself. I often overheard things about other people that dampened my resolutely positive attitude towards the workplace that had so generously agreed to take me on. I recalled a Spanish saying I'd once seen in someone's email signature: "Él que te chismes también dirá chismes sobre ti." That is, a person who gossips to you will also gossip about you. So true.

Right from the first couple of weeks, Jane frequently addressed me in a manner that I considered breathtakingly rude and which reminded me of the demonstration videos in the bullying and harassment workshops I'd attended at a previous workplace in a large government office. However, I was so determined to view my hard-won new job as wonderful in every way that I managed to twist even this into a positive aspect of the role by reasoning that she was like that with everybody, so at least I wasn't being singled out. Some people just have a brusque manner and don't understand that other people may take it personally, I decided. If anything, it was my fault if this made me feel bad, because I should be adept at brushing things off. Isn't that what resilience is all about? It took me some time to work out that she was just being careless with staff welfare, at least where it concerned mental wellbeing. Some nurses told me about a period in the previous year during which an injury had prevented her from maintaining her usually high level of physical activity outside of work. They reported that she was constantly frustrated and snapping at everyone around her until she finally recovered. This didn't sound very professional. No matter how good a clinician someone is, it's terrible form to take frustration out on employees, and it compromises patient welfare if those employees are then too shaken or distracted to concentrate fully on their work.

My colds and their after-effects (lingering coughs and general listlessness) affected me for about six weeks in total, probably because I continued to work through them. Because I had to dedicate spare time to rest and recovery, my interactions with people outside of work became almost absent. The resultant social isolation exacerbated the general feeling of being unwelcome in the workplace, to the point at which I didn't think I belonged anywhere in society. I could sense that I wasn't well regarded. I had not been confident in my abilities to begin with and I already felt frustrated with myself for not knowing or being able to do enough, so it wasn't a stretch to imagine that everyone else would be similarly dissatisfied with me. Although I don't consider myself to be intuitive, the feeling reminded me of being at school when the other kids decided I wasn't cool enough: the conversations that become more hushed when you enter the room; the inexplicable confidence with which your presumed faults are aired; the knowing looks exchanged when you say something awkward. In group chats with friends from uni, it was very difficult to dismiss my classmates' assurances that all new graduates feel that way sometimes.

Of course, very little was actually said to me directly, so all of this must have come across to my non-veterinary friends as pure paranoia. When anything was said, it was cryptic enough for me to be unable to determine whether it had a basis in hearsay. "Your nurses need to be able to trust you," Jane once said to me in a serious tone of voice, apropos of nothing. Well, yes. This was obvious enough. I nodded in agreement, wondering whether it was a general (though redundant) piece of advice or the consequence of some gossip about any one of a number of minor incidents that had passed around in Chinese whispers-like fashion until it became as big as Chernobyl.

A couple of after-hours staff farewell functions took place during my time at the clinic, and we were all invited to attend. These left me facing something of a dilemma. I knew that they'd be much happier without me, but also that my failure to attend would justify all the muttered misgivings they had and cement my reputation as an outsider. In the end, I would spend a precious weekend evening getting dressed up to socialise with people who were already unhappy enough to be stuck with me during business hours. Their forced politeness at these events was as bad as open derision. Back at work, I was wading through almost palpable hostility when I was in their presence, even when they outwardly smiled or asked perfunctory questions about my weekend. The fact that very little was said openly made the situation more stressful because it forced me to pour so much mental energy into convincing myself that I was just imagining it in order to continue to function. It was draining.

Consultations and procedures briefly provided a refuge from my colleagues. It is important to note at this point that my situation was not entirely negative. Despite the absence of mentoring and a growing sense of being an eternal outsider, there were things I loved about the job itself, right from the first week. On most days I was so busy I barely noticed how quickly the day was progressing, which was a pleasant change from the office job in which the clock-watching would start before 9:30 and I could practically feel the mental atrophy setting in. I was thrilled whenever I managed to learn something new from one case that I could apply to a different case. For example, on one occasion, when I was fortunate enough to observe one of Freya's consultations, I heard her explain to clients why dental problems were common in a particular breed. By an extraordinary coincidence, some clients I saw the following week asked me why their dog had bad teeth at such a young age, and I was able to impress them by offering a possible explanation. Learning and being useful to the clients replenished some of my energy and helped to compensate for the times when I didn't think I was doing much of either. Additionally, I was extraordinarily fortunate to have lovely clients, and I can't remember a single genuinely negative interaction with them.

Even some of the problems I was having were in large part due to things I saw as positive aspects of the job. The miscommunication over sick leave was an example of this. Obviously, it wasn't a good thing for me to feel that I'd be throwing the day's consultations into disarray by taking time out to recover, but this meant that my presence had to be of some benefit to somebody. At my office job I'd joked that if I taped a balloon to the back of my chair and put a wig on it I'd be able to take several days off without anybody noticing my absence. From that

perspective, my decision to become a vet was definitely the right one, as the work itself was giving me opportunities to be productive. It was just difficult to reconcile what I thought about the work with how I was being affected by the workplace. Given that small successes during the working day are sporadic but the workplace culture is pervasive, the former were always subsumed by the latter, especially as opportunities to learn from my colleagues petered out and I began to sense that they believed even Mr Bean would have been more competent than I was. Unluckily for them, Mr Bean hadn't submitted his CV to them. I'm sure they would have hired him. (I later found out from another vet that they'd tried to hire her, but she accepted a different position. So much for feeling grateful that they'd agreed to take me on; I was probably their only option.)

My brain began to take some seriously dark turns that were so at odds with my initial optimism that I barely recognised myself. There were even times when I caught myself fantasising about being murdered by an intruder demanding the sacrifice of an employee during a hostage situation. (Yes, really.) This, I reasoned, would neatly solve both the problem of feeling terrible at my job and the problem of being considered an undesirable employee. How could they totally dislike me after that? (Unsurprisingly, this situation never eventuated.) On my walk home, when I saw heavy vehicles pass, I wondered how quickly I'd die if one of them hit me. Of course, I wouldn't have taken any deliberate steps to make this happen, especially as it would have caused me to miss the compelling plot of *My Dad Wrote a Porno* on my MP3 player, but the image was persistent and somehow relaxing. I thought of it as a metaphor for my pressing need to switch off at the end of the working day, which at this point could only have happened if I simply didn't exist anymore. I absolutely hated being expected to answer questions about work at social events, such as extended family gatherings where those in attendance didn't know enough about me to make more engaging conversation, so I avoided those events. Whenever I saw anyone else going about their work, in any capacity, I wondered whether I'd be capable of getting into that industry as well: window cleaning, garbage collection, whatever people in suits did while talking on their phones and looking like posers... There had to be something in this world I could actually do well, no matter how insignificant it might seem to everyone else. However, all these jobs seemed somehow unattainable, as though I'd already demonstrated to myself that I would fail at everything.

It seemed that my resolution to make my colleagues feel justified in their decision to employ me was not working out at all, and this saddened me immensely. I didn't know enough and I couldn't do enough to believe that I was an asset to the practice. A more experienced vet and my unofficial mentor, Kenny, reassured me that new graduates usually cost the practice money for the first few months due to all the assistance they require, and it is likely to take at least a year for them to even break even after hiring one. The practice doesn't really begin to receive a proper return on its investment until around two years in, he explained. I wasn't sure whether this assertion was supported by concrete data, but it made sense: almost every job advertisement specified at least two years' experience. Kenny told me that leaving now, only a couple of months after starting, would be the worst thing I could do from my managers'

perspective. I wasn't completely convinced. If I was as bad as they surely thought I was, wouldn't it be better for me to help them cut their losses?

So certain was I that my employers must be regretting their hiring decision that I tried offering my job to a classmate (let's call her Brenda) whose offer of employment had been withdrawn at the last minute due to administrative changes. Simply quitting my job would be bad form, but not if I had a replacement lined up! I believed Brenda had a close relative living in the same city as my clinic, making the decision seem almost predestined. Brenda was a high achiever and very sociable, so I was sure that all the problems my colleagues had with me would disappear immediately following a quick exchange of one graduate for another. I imagined the relieved nurses smiling on her arrival at the clinic, making genuine conversation with her and remarking gratefully that she was much better than the terrible excuse for a graduate she'd replaced. I fondly hoped that they might also give me some credit for having done them such a service.

Brenda was alarmed to hear that things were so bad I would consider leaving, and she assured me that she could never take my job – besides which, she was looking for a position in rural mixed practice, and her relative had recently moved back to Sydney anyway. This came as something of a relief, because I still clung to the hope that my early self-doubt was an unfounded glitch in my thinking that would eventually form the basis of instructive stories I could tell to my friends in the year below. A few initial successes seemed to confirm this. There were times when I suspected my colleagues were happy with the way I'd diagnosed a condition or helped the practice get through the day's cases, and I was glad that my attempt to leave had been abortive. Maybe I was actually improving! My presence in the clinic may eventually be perceived as positive (or at least neutral) after all!

These bursts of moderate confidence were always fleeting, and there was still a disconnect in my brain between my feelings about my work and my workplace. Any consultation that I could manage on my own, without the need to ask for assistance, provided me with a reprieve from the general environment. Even euthanasia consultations gave me a sense of purpose. It was touching to witness how much these people cared about their non-human companions, and they were usually grateful to the person who was finally taking their pain away. Afterwards, most of them used their slightly choked voices to make a remark about how nicer it was than what humans were expected to tolerate. Of course, I could understand my classmates' devastation over some of their own euthanasia consultations, as shared with the rest of us through our social media page. They had needed to deal with cases that could have been medically or surgically managed if the clients had been prepared to pursue treatment, and this was heartbreaking for them, particularly when the client reasoned that purchasing a replacement pet made more financial sense than fixing the current one. However, mine had not been like that yet. In spite of everything else that was happening at the clinic, I truly felt that I must have won the client lottery.

It was odd that it was only in relation to euthanasia consultations that anyone—my colleague Veronica—ever once expressed a modicum of concern for my wellbeing. In that case, she'd

seemed appalled when I told her that I didn't mind doing three in a single afternoon to avoid a reschedule that would keep her back late, as though it made me macabre. I wondered whether she had attended a presentation on the impact of euthanasia on veterinarians and was going through the motions, without considering the far greater impact of an unsupportive work environment. Yes, it was sometimes mentally exhausting to walk home after witnessing upset clients who had farewelled their best friend forever, but it was exhaustion of a productive kind; the sadness was balanced by the knowledge that I'd given a peaceful end to a patient in pain in a manner that had offered some comfort to the loved ones. It was totally different from the mental exhaustion I experienced after a day of feeling despised, which was pretty much all the other days. If anything, Veronica's attitude towards my willingness to perform euthanasia was more upsetting than the procedure itself.

Similarly, there were occasions on which Jane ordered me to go outside and take a lunch break instead of using my break time to read through case histories for my afternoon consultations. Again, this was probably a case of having heard somewhere that it's important for employees to have genuine break time, and I fully concurred, but half an hour of enforced outdoor time is not really enough to foster a positive workplace culture when the employee is being snapped at throughout the day. It's also not particularly relaxing to worry about being underprepared for your next consultations.

Chapter Five

Some months later, in an episode of a psychology podcast that I'd downloaded for a car trip, I heard a Yale-based academic discuss the way that people's attitudes to work vary depending on whether they view the job as a calling. This helped to explain why I'd felt so disillusioned at work. This was supposed to be a career that required critical thinking and a sense of responsibility for decisions that I took ownership of, but I was forced to outsource my thinking to people around me with stronger personalities because I'd lost the will and the confidence to fight them. I found that most of the time I was an automaton following protocols and directives that didn't always conform to what I felt was best for the patient.

When we had a canine patient whose pancreatitis was flaring up, my supervisors recommended that she be kept on fluids overnight after she was stabilised. I called the clients to convey the recommendation, but I secretly hoped they would not agree to it. As soon as I'd hung up the phone, I confided to the experienced nurse, Sadie, that I did not feel comfortable about this course of action. Sadie had overheard the phone call and did not hesitate to agree with me. In her experience, the fluids rarely ran smoothly without monitoring: the machines would stop working, the anxious patients would become entangled in the lines and the very anxious patients would chew or pull them out. This is different from the situation at an emergency centre, where someone is present overnight to respond to the beeps emanating from the fluid pump alerting staff to a problem. Here, however, the patient would have to put up with these beeps all night, in addition to being alone in an unfamiliar location, with nobody to clean up any vomitus or otherwise deal with problems that might arise. At least at home the patient could be monitored and rushed to an emergency centre if her condition deteriorated.

This was a strange situation to be in. My studies and placements had given me the impression that the main problem vets experience in practice is that of clients who are unable or unwilling to comply with your recommendations. Here I was experiencing precisely the opposite: fantastic clients who were agreeing to something I felt uncomfortable having to recommend. I felt that I was betraying them and their beloved dog terribly. They should have been able to trust me, to know that I would not recommend something I didn't believe in. I was not being malicious; I adore dogs and I honestly cared about the best outcome for this one. It was simply a matter of bitter experience telling me that I was not in a strong enough position to oppose the directives of my bosses. However, I was the point of contact for the clients and the one whose name would appear on the paperwork if something went wrong, even though I didn't have any say in how it was managed on a practical level. I would be the one required to explain my actions. The excuse of "I had to do what I was told or risk making my own working life an even greater hell than it already is" would probably not suffice.

I lost sleep over that patient, wondering how she was faring in a dark, scary room without her humans nearby. It transpired that she did become entangled in the fluid line overnight, probably due to her distress. However, it also turned out that the nurse hadn't reduced the fluid rate as

she'd claimed to have done, and I hadn't double checked this. We discovered this through a note Jane had left on the cage door informing us that she had reduced the fluid rate herself when leaving the clinic an hour later. The nurse and I both felt bad about this, each in turn insisting on taking responsibility, although I really felt that it fell to me as the clinician in charge. Despite these feelings of guilt, the extra hour of high-rate fluids turned out to be beneficial, as the dog ceased to receive any IV fluids at all after twisting the line, so she wouldn't have been receiving any benefit from her overnight hospitalisation after about the first hour. All of this was so far removed from what I thought should have happened. I reminded myself that if she'd been at home, the clients could have monitored and comforted her. I was already feeling depressed at my general hopelessness, but now I hated myself even more.

This was not the only occasion on which the instructions I was given were at odds with what I wanted to do. Jane was staunchly opposed to the idea of providing non-steroidal anti-inflammatory drugs (NSAIDs), such as meloxicam and carprofen, if the client had refused blood work, which they often did on cost grounds. As a result, early on in my time at the clinic, an anxious dog was not given adequate pain relief after being treated for an aural haematoma when Janel was supervising me. The client presented her the following day because she had been in such immense distress the previous night. I wondered why we hadn't simply informed the client of the risks and kept a record of the fact that he was prepared to accept them. As far as I was concerned, the certainty of serious discomfort to the dog outweighed the risk of exacerbating hypothetical renal or hepatic problems in a healthy patient with no clinical signs of either, especially if they would only be used for short-term pain management following a procedure. I understood that Jane viewed things differently, perhaps trying to err on the side of caution, but that didn't stop me from feeling that I had failed in my duty to advocate for the patient's welfare. Maybe I could have made a convincing case for my point of view if I'd felt comfortable talking to Jane (which I obviously didn't), and perhaps she would have agreed if she'd had any respect for my professional opinion (which she obviously didn't). The dog's discomfort gnawed at my conscience. It was a situation I would consider unacceptable if I'd been a patient myself, and a large part of my reason for entering the profession in the first place was to alleviate suffering in patients who could not speak for themselves.

When a similar situation arose later I still lacked the courage to be a fearless advocate, but I did what I could on the sly. A dog had yelped when I'd attempted to take his temperature as part of a routine clinical examination. Dr Freya had once told me that this often means the anal glands are impacted, so I took the patient out to the treatment room to investigate. Jane was present and, on discovering why I had the patient there, ordered that I take the temperature before expressing the glands. I decided against this; I had only brought the dog to the treatment room in the first place because he couldn't tolerate the procedure, and I wanted to make him more comfortable first. The pain he experienced when the thermometer was placed could also have falsely elevated his temperature, making it far more difficult to interpret. Freya's advice proved helpful on this occasion: the glands were severely impacted but easily emptied. Afterwards, the patient was able to tolerate the thermometer easily, without yelping, and the temperature was normal. This, I decided, was a good outcome for all concerned, and I was happy that I'd done

my job properly, but it bothered me somewhat that I'd needed to disregard instructions in order to do it. (Of course, Jane found out about this later and severely chastised me for not having done what she'd ordered.)

The tug-of-war between doing what I felt was right and what was asked of me continued, though. On grabbing some vaccine vials from the fridge one morning, I was surprised to find that they were at room temperature. I informed Veronica that the fridge didn't seem to be on, and after confirming that this was indeed the case she went to discuss it with Jane. Jane made the decision to continue using the vaccines in any case, accompanied by a stern warning to anyone using the main consult room (where the fridge was located) to check that the plugs didn't come loose at the end of the day. The decision about the vaccines was primarily based on the fact that we didn't have any others at the clinic. Presumably, it would have been too costly to reschedule all the vaccination appointments pending the arrival of new ones.

I had misgivings about charging clients the same amount of money for a product that hadn't been stored properly, but I tried to rationalise the decision:

- The experienced vets would know more than I did about this, and they wouldn't want to do anything that would jeopardise their reputation, so everything must be fine.
- It was early autumn and although the days could be hot, the nights were mild.
- Food left out on the bench for one night is usually perfectly fine to consume.
- Expired vaccines are frequently donated to and used by animal rescue organisations.
- In the worst case, I knew this was an area with good herd immunity thanks to high vaccination rates, and I reasoned that the clients dedicated enough to vaccinate regularly might be good at observing other practices that could help reduce the risk of infection. (I deliberately avoiding looking for peer-reviewed papers confirming this.)

Despite this, I'm ashamed to admit that my concerns about the efficacy of the vaccines were actually secondary. The primary feeling, by a wide margin, was one of relief that I hadn't been the last one in that consultation room the evening before. I hadn't previously paid any attention to the power board there, but the fridge incident made me aware that its location and burden of plugs would have made it very easy to knock out slightly, and if it had happened on my watch I probably wouldn't even have noticed in the midst of my preoccupation with the consultation itself. It just wasn't something I'd ever thought to look out for. Perhaps it was only because I normally worked from the second consultation room that it hadn't happened to me already. If I'd been the last one there that day, I would certainly have been made to feel responsible for what had happened. And I would have been reminded of this act of perceived carelessness at every available opportunity thereafter.

Chapter Six

Everything I did at the clinic, especially in my first month, made me feel like a walking disaster. I accidentally vaccinated a table with a rabbit vaccine that was in short supply (my term for inadvertently pushing the needle straight through the skin fold and out the other side, necessitating a second injection); I failed to add a heartworm injection to an invoice; I used tropicamide instead of tetracaine eye drops in an eye I was about to examine, thanks to the identical-looking vials and adjacent positioning in the fridge, which meant that I had to advise the client to keep the patient away from light for the next few hours... I wondered how I could possibly be so bad at everything. I remembered that during final-year rotations, my friends and I could answer about as many questions as each other (though not necessarily the same ones) and did just as well in the assessment tasks, but there was no way that anyone could have convinced me that our performance at work was similar. I imagined that they were managing everything without trouble, except for the problems caused by circumstances outside their control.

Just after starting at the clinic, I was in the room while another clinician was managing an induction that wasn't going well, and I was eager to feel useful by drawing up some more of the induction agent alfaxalone as required. The nurse mentioned that I'd reached for the acepromazine instead, so I quickly switched the bottle for the correct one. Then, thanks to my moronic upside-down reading of the syringe, I drew up less than requested; the clinician pointed this out and I drew up extra. Of course, I felt like a complete idiot, because I'd been so eager to show that I could be helpful. I made a valiant effort to fight my natural tendency to dwell on the incident to the point at which I'd be paralysed with a fear of failure. A report of this incident was apparently given to Jane, because she asked to speak to me about it. I was told that it was irresponsible of me to come to work when I was too unwell to function without codeine (which I had taken because my colleagues were bothered by my persistent coughing, and not because I felt sick), because this was causing me to get drugs and doses wrong (both words used in the plural, for some reason), creating a dangerous situation. I personally didn't blame the codeine or my illness for this; it was purely a case of overeagerness. Of course, I was already feeling bad about it, so I didn't know what she was trying to achieve. Did she think I'd done at deliberately, just for fun, and that I would make a conscious decision to stop if I was told not to?

What I didn't mention at this discussion was that in the week in which this incident took place I'd also prevented Michael from drawing up the the wrong drug in a similarly fast-paced situation, when he'd reached for the wrong bottle from the two that were available and I just happened to witness it. I'd viewed this as evidence of successful teamwork rather than a failing of any particular individual, so I didn't think anything of it at the time. On this occasion, Michael had been using a slightly less mainstream induction protocol, but certainly one he had used before in the course of his decades-long career. Did the nurse present report to anyone else that I had prevented someone from drawing up the wrong drug? If so, I never heard about it. Some time later, the same nurse casually mentioned that this was not an uncommon occurrence with Michael, and that she and the other nurses frequently had to call him out. It was not said with

any malice; it was more like a proud acknowledgement that adorably muddle-headed clinicians would be lost without the assistance of practical nurses. Again, this was evidence that the system was working, because, thanks to the nurses, he didn't end up administering the incorrect drug or dose. Why, then, was this type of thing viewed as evidence of my ineptitude relative to everyone else's?

On another occasion, when I was asking a different nurse to teach me her bandaging technique on a patient (something we hadn't really covered in the degree program but which I was keen to master all the same), she affectionately remarked that Michael was hopeless at bandaging, always having to rely on the nurses. He was also notorious for failing to enter his S8 drugs into the book, sometimes falling behind by a couple of days if his colleagues didn't remind him or, in the case of other veterinarians (including me on a couple of occasions), sign off on the drugs themselves if we'd seen him use them.

It occurred to me that this may be an example of the different expectations faced by women and men in the industry. A man with scatterbrain tendencies appears to be regarded as a kind of savant, and considered to have even greater clinical expertise – the socially inept scientist stock character I'd seen in American TV shows and movies as a child. Poor organisational skills and illegible handwriting are almost prerequisites. After all, a genius who is preoccupied with solving important problems should really not be expected to be able to do the job of a receptionist, a nurse or a kennel hand, which is why people with complementary skills are employed to do that work for him. Conversely, it seems that women are considered to be completely unsuited to clinical reasoning if they are not supremely competent at the administrative and practical jobs; they must be good at bandaging, answering the phones and tidying up after themselves. These are all useful tasks, of course, but they add up, meaning that someone who is not expected to perform them regularly eventually has more time and mental bandwidth available for the veterinary side of the job.

Staff members at the clinic appeared to anoint other staff members as either good or bad, and the relative merits of whatever they had done would be determined as positive or negative depending on which of the categories they already fell into, rather than whether the action itself was good or bad. This phenomenon is common among humans, of course, and hardly confined to workplaces. I once watched a documentary on SBS (*Every Family's Nightmare*) that compared different approaches to investigating a crime: the nominative and eliminative approaches. While the eliminative approach is based on investigating a large pool of potential suspects and using the findings of the investigation to eliminate them, the nominative approach is based on selecting a suspect and building a case around them. Something to do with confirmation bias. According to the documentary, the latter is considered to be a poor approach to investigation by the world's more respectable police forces, because the tendency is to try to make the evidence fit when it probably doesn't.

Office politics can function as a real-life application of such an approach, and your life can be miserable when you begin to sense that you've been "nominated". I noticed that other clinicians

could get away with making similar or worse mistakes while maintaining a “good bloke” reputation that made everybody (even me) admire them nevertheless. Perhaps this came from appearing relaxed, which I definitely didn’t. (In fact, I was becoming tenser with every passing day, and my abysmal acting skills would not have helped me conceal this.) It seemed that a dark cloud was hanging over everything I did, sapping any feeling of satisfaction I may have derived from small successes that would otherwise have served to keep me motivated.

Chapter Seven

One of those who had been nominated as a “good bloke” was a locum called Steve who occasionally worked at the clinic. He was one of the few who didn’t mind having me observe his consultations if I had a couple of cancellations, and he would even chat to me in a friendly manner in between them. I once confessed to him my anxiety that I might administer the incorrect vaccine one day, given that the vials looked so similar and were located on the same shelf of the fridge. “It’s almost a rite of passage to give a dog vaccine to a cat!” he laughed. This was one of the only times I felt remotely relaxed at the clinic, when I didn’t think a small error would spell the end of the world. Yes, we’ll make mistakes, but we don’t need to beat ourselves up over them. I recalled that some of my best experiences as a final-year intern were when clinicians had let me know about all the silly things they’d done throughout their careers, particularly as new graduates. At first I was alarmed, concerned that I might do the same things myself, but it occurred to me that these people were still doing good things in practice and well regarded by their clients. They viewed their past failures as a part of their professional development. Being around them was hugely helpful.

The attitude at this clinic was quite different. I once overheard a nurse mention that Jane had accidentally stabbed a client with a needle during a routine vaccination and had needed to provide the client with advice on what to do next. This sort of thing happens; some patients can wriggle unpredictably when being held, and clients aren't always good animal handlers. However, I knew that if this had happened to me I would never have heard the end of it. It would have been the subject of a grave discussion about my general carelessness or not taking the job seriously enough, on top of the devastation I would have felt in any case at having done something like that. There would have been no calm reassurance that this happens to the best vets, or encouragement to view this as a positive experience that would allow me to learn how to manage such a situation—which, incidentally, would have been a helpful thing for Jane to have gone through with me for future reference when it happened to her, even though I hadn’t been present at the time. It almost seemed that other clinicians’ mistakes were being deliberately concealed from me in order to make me feel even worse about my own. Why would they do that? It certainly wasn’t helping me feel less anxious or otherwise improve my performance as a clinician. Was it a manipulation tactic to make me less inclined to request a future pay raise?

Similarly, there was a time when I saw two of Jane’s post-castration complications on the same day. The procedures had been two of the three or four she had performed a couple of days earlier, on one of my rostered days off. Postoperative swelling, infection and suture failures are not uncommon. Patients are supposed to avoid being too active for at least a week to allow healing to take place, but young, energetic dogs are not known for their ability to follow discharge instructions to the letter. The problems usually resolve on their own or with a simple course of anti-inflammatories and antibiotics. What terrified me was the knowledge that, had I been rostered on to do surgery that day, these castration cases would have ended up in my column. After all, castrations were among the only procedures I considered myself to be

capable of performing. The patient outcome would almost certainly have been the same, but I was absolutely convinced that it would have been viewed as reflecting poorly on my technique and level of care. My two-out-of-three complication rate would have been the subject of caustic gossip for weeks or months afterwards. That it was purely the luck of the roster that had spared me from this was a sobering thought (if further sobriety had even been possible at that point).

Chapter Eight

Of course, I wasn't always lucky enough to escape from the challenging surgical cases. When a client called to book his early-pregnant dog in for spay surgery, I looked at the scheduler and discovered that I would be rostered on. I had never spayed a dog in early pregnancy before. Was this something I ought to be able to do? I didn't even know how the inside of such a patient should look in real life. I knew that an in-season spay was something for experienced vets, because the vessels are so friable, but pregnancy is different. I had once spayed a pregnant cat, and it was actually easier to see everything. Finding the uterus during surgery is notoriously difficult in some patients, but it's rather hard to miss when it's gravid. Michael was sitting nearby and I asked him whether he thought this was something I'd be able to manage. He told me I could if I was "confident", to which I replied that I was never entirely confident in anything I did, and probably wouldn't be for some time yet. That was all the advice he was prepared to offer. The deciding factor for me was that Veronica would also be rostered on that day, and I could ask her for assistance if I needed it. Nevertheless, I was nervous when walking to work that day, and I wondered how I would feel on the walk home. Would the procedure turn out to boost my confidence or dismantle it utterly?

Suffice to say that the procedure only went well thanks to Veronica's assistance. The ovarian pedicle virtually dissolved when I clamped it, which allowed me to fully appreciate what my lecturers had told us about vessel friability. For some reason it still clotted immediately, but Veronica, who had plenty of shelter experience and was an old hand at mature, large-dog spays, still spent some time attempting to retrieve it in order to ligate for good measure. She decided to finish the rest of the procedure herself, leaving only the closing to me. The whole experience was quite alarming, despite the good outcome for the patient.

Veronica did me the courtesy of mentioning to the principals that it was a "9/10" difficult case. Michael casually remarked that an early-pregnant spay is essentially the same as an in-season spay. Why hadn't he mentioned this when I was booking the procedure and asking whether it would be suitable for me? At least the other clinicians seemed to acknowledge that it wasn't a procedure an inexperienced surgeon could easily have managed, even with considerable care taken, but something about this stated support was unconvincing. I detected that I'd failed some sort of test. Later on, I also wondered whether the nurses who'd assisted me that day were privy to this information about the difficulty level of the procedure, or whether they viewed it as an example of ineptitude on my part. They wouldn't have understood what was actually happening in the patient; they would only have seen that I was struggling and that someone else needed to help me.

That evening I was glad to have the opportunity to debrief with a friend working at a different clinic over shared surgery fails. It was strange that I'd managed to get through two demanding degrees and numerous other trying experiences in life without recreational drugs, but now I understood their appeal.

Not long afterwards, during another spay, I realised just after incising a pedicle that I had failed to keep a clamp on an ovary. It was my first experience of such a problem, so I froze for a second, then uttered expressions of alarm that must have confused the nurse assisting. (Seriously, I'd be a terrible poker player.) However, the ovary was recovered successfully and I completed the surgery without any further problems. The nurse, Vera, still didn't know what I'd been worried about, but she was an immensely practical worker and simply continued to do her job, satisfied that the patient was doing well under anaesthesia. There was no bleeding, possibly due to the time the haemostats had been in place before I had removed them, and the rest of the operation proceeded without problems. However, when Jane afterwards asked how it had gone, I made the mistake of acknowledging that it had been a success despite the problem with the haemostats.

Of course, this incident was thenceforth repeatedly brought up to remind me of how bad a surgeon I was and to make the point that I could still not be trusted without a supervising clinician around. Honestly, I didn't mind having another vet around while I was performing surgery, because I considered patient welfare to be more important than any cocky display of independence on my part, and I liked the thought that I might learn some new tips or anatomical trivia. It was strange for Jane to portray it as an almost punitive requirement; I'd never previously demonstrated an unwillingness to ask for help when it was needed. Unless there was some genuine mentoring involved, it would have made more sense for me to request assistance if a procedure was unexpectedly challenging, and to have the start-to-finish hoverer present for unpredictable or unfamiliar procedures.

Chapter Nine

My friend and unofficial mentor Kenny told me, given that my colleagues were not outwardly expressing any desire for me to leave, that I should at least wait until my three-month review, because it would be bad form to leave them voluntarily before they had a chance to see a return on their investment. That review eventually arrived without warning, and it involved both Jane and Michael scheduling a time to talk to me in a vacant consultation room. I had no idea what to expect. The reassurances from friends and my history of imagining things to be worse than they really are had led me to suspect that it could be good news after all. Of course, this was not to be the case. The first thing Jane said, even before greeting me, was that they were in a difficult position because they had never had such a bad graduate before. The cliché of the colour draining from one’s face was one that I had never properly understood before that moment. I could feel everything above my neck turn colder, as though the blood had decided to abandon ship. Where was it going? Perhaps it was headed to my heart and skeletal muscles, gearing up for a fight-or-flight response. Being naturally more inclined towards a “freeze” response, however, I actually seemed to benefit from this. My usual hyperactive overthinking and fidgeting gave way to a frozen stillness that may have resembled calmness.

Jane went on to explain that they had previously worked at clinics that had taken on new graduates, and that they had all been much better than I was. This qualifying statement about the other clinics was necessary because I was the first new graduate they had taken on at this one, and I was obviously aware of this, so I was clearly the worst (and also the best) they'd ever had. Despite this, they may have forgotten that I had actually undertaken a university placement at their previous workplace and knew that it was run quite differently. For example, there was a much sharper divide between the work of receptionists and the work of clinicians, meaning there was no pressure on the latter to occupy themselves with non-clinical work. There was also time set aside every week for professional development. Perhaps these had not been factors when Jane and Michael were working there, but I was highly suspicious that there were other differences they weren't acknowledging. I'd felt welcomed at that particular clinical placement; I also knew that Jane and Michael spoke very negatively of it, although the circumstances under which they'd left were mysteriously never spoken of.

The first matter for consideration was that I’d had a couple of spays that had not gone well, referring to the in-season spay and the haemostats I’d removed prematurely. (Actually, they had both gone well in the end, although I couldn’t take any credit for it in the former case.) They acknowledged that an ovariohysterectomy was a challenging procedure, but nevertheless qualified this comment with words to give the impression that I was a poor surgeon who should be far better by this stage, after having performed half a dozen procedures already.

They then mentioned that in the leadup to this review they had asked other staff members to provide their views on me, and that several of them had expressed concerns about specific incidents. Among the most serious was that I had recently asked a nurse for assistance when running a cPLI SNAP test for the first time on a patient with suspected pancreatitis. Jane asked

me why this was necessary. She contemptuously mentioned that this test was so easy to run, with all the instructions in the box, that even the nurse straight out of high school would be able to manage it.

I honestly had no idea that this was even a problem. I couldn't recall the nurse having mentioned this as being an issue at the time. I thought that asking for assistance from someone who had run the test before, and who would be in the treatment room to look at the results at the prescribed half-hour point (instead of rushing in and out of consultations, as I was doing) was a way of delegating responsibility—something that Jane herself had tersely stressed the importance of doing when I had once asked about ways to keep track of timed tests while consulting. It had also been extremely difficult for the nurses to draw even the few drops of blood required from this patient, so did it really hurt to double check that everything was in order with someone who had plenty of experience running the test to avoid wasting it with poor technique? Apparently it did. The fact that the nurse had not raised these concerns with me at the time, but had instead complained to someone else later, served to enhance the underlying sense that my work was being undermined by cliques and subterfuge.

The next item in the extensive catalogue was that I did not have the requisite skills to be a clinician. This was based on an incident the previous week in which I had detected a low temperature (somewhere in the high 35s) in a canine patient with a history of inappetence and vomiting following a routine vaccination a few days earlier. This was the lowest temperature I had ever detected in a conscious dog, to the point that I'd seriously doubted that I'd positioned the thermometer correctly. The dog had appeared rather stiff and inactive, and his limbs were damp from having walked through the wet grass to reach the clinic, both of which I suspected of contributing to the low reading, but I was concerned about his condition more generally, particularly due to the three- or four-day history of inappetence. I recommended blood work, which the client declined on cost grounds, although I stressed that it would be very difficult to learn any more about the dog's condition without it.

I had then gone to see Jane in the treatment room to discuss the case with her, including my clinical examination findings and my blood work recommendation. She told me to inform the client that this was a highly unusual vaccination reaction and recommended a pancreatitis test due to the history of vomiting, which would be marginally less expensive than full blood work (although it would only provide information on one possible cause). The client agreed to this. I also administered an antiemetic injection, hoping that if nausea was contributing to the dog's inactivity and inappetence, this might bring him to the point at which he could at least start moving and eating again. I advised the client that I was concerned about the dog's condition and urged him to return the patient to us before our closing time if there was no improvement.

The pancreatitis test was negative, and the client did not return that day. The following day he presented the dog to the clinic again, when Michael was consulting. The patient had still not eaten anything following the previous day's antiemetic injection, and his condition had actually deteriorated. Michael took his temperature and found that it was now in the 33s. Reading

through my case notes from the previous day, he caustically mentioned that he would already have been worried by a temperature in the 35s. I actually had been, I explained—it was so low that I was even worried I hadn't taken it properly (even though I was sure I could feel the thermometer in the right position, and said so to the client at the time). He angrily told me that if I wasn't sure, I "should ask". He then dramatically turned away from me to storm back to his consultation room to speak to the client again. I had to give him credit for the impressive display of flouncing.

This time, because the dog's condition was so dire, the cost considerations associated with the blood test were no longer quite as important, and Michael was able to convince the client to go ahead with it. The results revealed a low sodium-to-potassium ratio, making hypoadrenocorticism, otherwise known as Addison's disease, our top differential. This helped to explain the "vaccination reaction": it was not a reaction to the contents of the vaccination itself, but rather to the stress occasioned by the clinic itself and insufficient stress hormones to cope with it, leading to an Addisonian crisis. The blood test I had first recommended to him on the day would have led me to this diagnosis more quickly, even with my limited experience, this diagnostic test having featured in several practice questions for the North American Veterinary Licensing Examination I'd passed a few months earlier.

In short, the skills issue was that I had doubts that I was accurately recording the temperature, indicating that I was not capable of taking a temperature correctly. This puzzled me. Michael recorded an even lower temperature when the dog was in a worse condition the following day, so surely this was an indication that the low temperature I had detected was indeed an accurate one? And if it was accurate, how was this a sign that my skills were poor? I imagined it was better to arrive at the correct reading with some lingering doubts about my ability than to be a model of the Dunning-Kruger effect and never question it.

In summary, I had recommended the most appropriate diagnostic test. I had given appropriate follow-up advice to the client (which was not followed). I had written thorough clinical notes. I had also discussed my concerns about the case with Jane, whose recommendations I had followed to the letter (and who, of course, said nothing in my defence at the present meeting.)

The next item related to blatantly disregarding instructions. I was reminded of the time when I'd expressed the dog's anal glands before taking a temperature. The nurse who had been present that day, a recent school leaver called Candy who had just joined the clinic after a successful work experience placement, had heard Jane tell me to take a temperature beforehand and had mentioned this when she saw that I was expressing the anal glands first, but I explained to her my reasons for doing it my way, and I believed they were good ones. This nurse was fine in terms of technical skills (certainly better than I was when it came to her routine tasks such as bandaging and setting up IV fluids), but it was evident that she did not understand the concept of clinical reasoning. That the patient was otherwise healthy, for example, and that there was no indication for the procedure, did not feature in her analysis of the situation. Her only consideration, apparently, was that Jane was always right and I was always wrong.

Interestingly, Jane herself did not take every patient's temperature during consultations. On one occasion, subsequent to this discussion, she asked me to look over some blood results that were due to be sent to us on her rostered day off. The patient had an astonishingly high neutrophil count, including a band neutrophilia, but there was no temperature recorded in Jane's consultation notes. I could understand why this would have been: the patient was large, anxious and not suspected to have an infection. The blood was being taken because Jane suspected she had degenerative joint disease and the results would be helpful in planning a management protocol (e.g. determining whether she could cope with certain anti-inflammatory drugs). However, the band neutrophilia would have been easier to interpret in light of a temperature, and this patient had presented unwell, unlike my anal gland patient.

The next issue was that I had been present during an induction that was not going well and which needed to be remedied. "The nurses just dealt with it properly, and you panicked," she declared. Well, that made sense. I hadn't encountered this problem in real life before and needed to think about what was happening before acting. In the time it took me to mentally summon pages of theoretical anaesthesia notes from my lecture-based training, the nurses had already fixed the situation by doing what their own practical-from-day-one training and experience had taught them to do, and it turned out to be quite a basic, commonly encountered problem that was easy to solve. That was the very hands-on experience I had been hoping to acquire at work, but this lack of experience had led to a general consensus among the other staff members that I was not suited to clinical work. Would I have managed to resolve the situation myself if the nurses hadn't leapt in there first? I'd like to think so, but by that time I was already paralysed by a reluctance to do anything that was not completely perfect when I was in my colleagues' presence, and because nothing can ever be completely perfect, this made it hard for me to act at all.

When I had undertaken a rotation at a behaviour clinic the previous year, the specialists made a point of telling clients that anxiety makes it extremely difficult to think effectively. As an example, they asked the clients to imagine they were confronting something very scary to them—being surrounded by spiders, for example, or standing on the edge of a cliff—and to answer a challenging arithmetic question, such as multiplying two large numbers. They admitted that they would probably freeze and struggle to respond. Then they asked the clients to imagine working out a simple arithmetic question, e.g. "two times two", in the same situation. The point they were trying to make is that this knowledge is so ingrained from prior experience that it's easy to summon, even in stressful situations. Learning something in a calm (or perhaps a frantically busy but nonetheless supportive) environment helps to cement the information so that it may be called on later. Was this what I was experiencing? Or was I just far less capable than anyone else would have been in a similar situation? Jane and Michael were telling me quite clearly that it was the latter.

They also told me that I wasn't yet capable of working the sole-charge Saturday morning shift, which they wanted me to do.

Sole charge? Are you kidding? I still hadn't received any training in managing emergencies when I'd been rostered on with someone else. My role in emergencies was closer to that of a student than that of a practising veterinarian: stay out of everyone's way and don't bother the real vets while they're trying to work. The directive to nurses and receptionists to book only "simple" cases in my column had been issued by the very same people who were suddenly berating me for not having the requisite experience to take sole charge. These contradictions were so immediately obvious to me that I didn't even bother to point them out. It occurred to me that I'd been set up to fail, and this knowledge was both liberating and powerful, acting as an armour to protect me from taking the onslaught of personal attacks seriously. The fog of self-berating thoughts began to clear as it became apparent just how ridiculous the situation was.

The next serious transgression in the catalogue was that I had misunderstood a discussion about leave. I had received an invitation to attend a wedding overseas, and given that I had missed other overseas weddings throughout my degree program due to study commitments, I was eager to finally attend one. I felt encouraged when the calendar revealed that my preferred leave period did not coincide with any school holidays, when the clinicians with children might want to take leave. After a couple of days spent trying to catch Michael, I eventually managed to approach Jane with my intended dates. I only had a week of leave accrued, but she seemed happy for me to purchase another week or take an advance on future leave, especially as it would put less pressure on the school holiday times later. After we had discussed the dates, she seemed satisfied and told me I could then get back to her once I'd looked into flights. I took this to mean that I should book the flights, because fares have a tendency to fluctuate almost hourly, but it seems I was mistaken, and that I was literally expected to merely look into the flights. Learning of this mistake finally clarified why I'd never received any kind of reply to the email I'd sent Jane with the flight details and when I would be able to return to work.

Jane suggested that this misunderstanding was a sign that I struggled with communication generally, and that I must, therefore, also be having problems communicating with clients. With a furrowed brow, she then asked, with affected concern, if I had received many specific appointment requests from clients. It was essentially a rhetorical question. I'd only been there for three months—not long enough for most clients to return to the clinic for the routine matters I dealt with, such as annual vaccinations—and other staff members had been given an express directive not to book any new clients in with me for most of that time, so almost all of the clients I saw already had an existing relationship with one of the practice's other vets and were only seeing me because they weren't available. Under such conditions, the fact that I'd had any specific appointment requests at all (about two or three at this point) was remarkable. I responded to Jane's question in the negative but didn't elaborate. There was no point; the discussion had reached a level of absurdity that was beyond the power of logical reasoning to clarify, and I wasn't going to try. I also judiciously avoided mentioning that having worked in the same jurisdiction for many years without being aware of the desexing legislation could also be interpreted as a sign of inadequate attention to detail if one was going to draw such a long bow.

The closest I came to defending myself was a rather weak counterattack, by mentioning that I'd felt very uncomfortable about having to recommend overnight fluids for the pancreatitis dog. This was really because it had been gnawing away at me for weeks and I hadn't wanted to offend anyone by stating the obvious: that it was a very bad recommendation for that patient, and I shouldn't have felt pressured to make it. Now that I realised I bothered everyone no matter what I said or did, this no longer mattered. However, Jane and Michael struggled to even remember the patient, eventually looking her up in the system when I recalled her name. They dismissed my concerns by implying that I mustn't understand the benefits of fluid treatment for dogs with pancreatitis. Apart from this, I maintained as calm a demeanour as possible as I allowed the torrents of verbal dissatisfaction to wash over me, as they continued to do.

Jane told me that, in the near future, I'd be expected to be able to finish consultations in the usual time of twenty minutes. I'd seen that one coming for a while, and I also knew I wasn't up to the task. I was still being given generous half-hour consultation slots, ten minutes longer than the usual allotment, to allow for the fact that I was a new graduate and would take longer than a more experienced veterinarian to carry out the same tasks. I also had just as many "break" consultations scheduled as they did (although we all had to pick up last-minute appointments that tended to be squeezed into those slots). This meant that I was very often the only clinician who was running on time. I'd lost count of the number of times I'd picked up a colleague's consultation because they were two consultations behind. Veterinarians rostered on to finish at two in the afternoon (usually to allow for the fact that they were doing a Saturday morning shift that week) would routinely finish at three or four because they'd darted from one consultation to the next and hadn't had a chance to write anything up. Finishing on time was almost unheard of.

Although it should be possible to carry out a basic vaccination consultation in twenty minutes, a lot of factors outside of the clinician's control can interfere with this: clients running late; the extra questions that require further investigation; the ear problem picked up incidentally that requires time to perform an otoscopic examination and stain slides prior to diagnosis; the cat who needs to be taken to the treatment room and whose carrier needs to be disassembled and reassembled at least twice because he won't leave it voluntarily…

If the clinicians with (in some cases) decades of experience were unable to stay on top of the twenty-minute consultations, what hope did I have? As a new graduate, I didn't yet have the pattern-recognition database that takes time to develop. Developing a systematic approach to arriving at a diagnosis, with problem lists and carefully considered differentials, is recommended practice but takes time, so I generally found it necessary to bypass these steps and ask someone more experienced for their opinion (which I gradually began to also use as a way of covering myself in case someone attacked my decisions later). However, I wanted to move beyond that and to learn proper clinical reasoning. At around this time, some of my classmates were discussing unpaid overtime on our year group's Facebook page. One of them worked out that her actual hourly wage worked out to be around $17—that is, less than she'd been earning at her student job in a supermarket. At this stage of my career, I wasn't quite as concerned

about the time and money as I was about being set up to fail. Staying back late was one thing, but I was too mentally exhausted to sign up for being on the receiving end of yet more grumbling because I hadn't managed to fit everything in earlier. I was tired of being a constant disappointment. The expectation that I should also answer the phone would start to become a problem, because some of these calls could end up taking quite a long time as clients ummed and aahed about their availability and attempted to launch into long stories.

There wasn't really much for it but to suggest that perhaps I wasn't a good investment for them. They looked a bit surprised, although whether it was feigned or genuine I couldn't tell. They must have been hoping for this outcome? I didn't want to give them too great an insight into what I was thinking, but I did mention that a friend at the RSPCA had told me about the possibility of doing some desexing there on a voluntary basis out of hours, which I may be able to combine with an unrelated job.

Jane expressed backhanded approval of this plan, stating that it would be good practice for me to work with animals who did not have owners. That was probably the most astonishing part of all. Was she implying that I didn't care about the patients, and viewed them as disposable if there was nobody to stand up for them? Or perhaps that I had trouble dealing with clients? I did not believe I was less concerned about my patients' welfare than anyone else at the clinic. Similarly, nothing that I had said or done suggested I did not enjoy client contact. I noticed that other clinicians and nurses complained far more frequently about client trouble than I did, which I had always assumed was due to my lower caseload and extraordinary good fortune in managing to see wonderful clients. In hindsight, I began to think it might not have been luck after all. This was a part of my job that I truly enjoyed.

Chapter Ten

The entire discussion seemed to be building a case for my voluntary removal from all of their lives. There was nothing promising in this talk, and nothing that hinted at professional development. Most of the time I just nodded passively (calmly, even) and outwardly agreed with everything. Not feeling confident in my practical skills to begin with, it was easy for me to believe that my bosses' assessment of my general ineptitude was an entirely accurate one. It was also, oddly, a relief. Even the tiniest focus on any positive attributes might have motivated me to throw myself into the work, which would have been bad for me in the long term, as this environment obviously wasn't good for me. That I was simply not the right sort of person for this type of work, with no redeeming features whatsoever, meant that I didn't have to try anymore, and I'd been trying so hard that I was almost overjoyed to be let off the hook. It was, finally, a revelation of what I had long suspected. It brought to mind something Solzhenitsyn touched on in *The Gulag Archipelago* when he mentioned that some people experience relief on being arrested, because the knowledge of the impending arrest produces more anxiety than the arrest itself.

It occurred to me that I didn't need to put up with this. Failing at my job did not amount to certain death. I didn't have children, a mortgage, a relative being hounded by loan sharks… and, come to think of it, any one of those things should have given me an even stronger impetus to leave, as the pay in the industry is notoriously poor. I wasn't there for money. I was there to help animals, which I kept hearing I wasn't doing very well, and to gain experience, which seemed to be at odds with my assigned tasks. Moreover, they didn't seem to want me there anyway. It was really a win-win situation. (Or a lose-lose one; it didn't matter if it amounted to the same thing.)

There was something else happening here, though. I had spent a large part of the preceding three months beating myself up over all the things that I hadn't been able to do perfectly, thinking I was useless and that I was letting everyone else down. However, hearing these transgressions articulated by someone else made me realise they weren't so bad after all. Paradoxically, it was only the principal vets' explicit dissatisfaction that made me doubt whether the metaphorical self-flagellation was justified. If the examples they were using were so weak, perhaps I hadn't done anything truly terrible? And maybe I was just being set up?

An indication of this came from the manner in which the review was carried out. It is always poor form to save up negative comments with which to blindside employees in one hit. This was the main message that had been drummed into us in the feedback information workshop I had once attended at a previous workplace, but common sense would have made this obvious even without a specific training session. In my experience, when supervisors neglect this, it is usually because they're intentionally setting out to ambush. This situation appeared to be no different. My outwardly calm response to my supervisors' words even appeared to annoy them somewhat, which may have explained the increasingly silly tone the conversation was taking. Perhaps they were trying to goad me into crying, or at least clambering to offer a justification, but I was too numb to do either of those things, at least initially. I was depriving them of their kicks.

Towards the end of the discussion I was feeling much lighter. The focus on these particular issues was evidence that the problem had more to do with how I was perceived as a person than what I was actually doing. When you have a problem with the person, you'll make an effort to find fault with them. It was futile to worry about what I was doing wrong because I knew I would be perceived as a failure no matter what I did.

What was abundantly clear was that if there were any adverse patient outcomes on my watch, I was going to be thrown under a bus. This would be the case regardless of whether I could have done anything differently or I was acting on the orders of a more senior clinician. I would be fully aware that whatever happened was the result of a degree of incompetence to which I alone, in the entire history of the profession, could lay claim. There would be no support, no stories about how similar things had happened to other fantastic vets early in their own careers, no moving on. If I found myself the target of a vicious social media campaign led by a disgruntled client who was upset about our prices or inability to save a patient, I would be left to fend for myself. I, and not the complainant, would be viewed as the problem. Perhaps the Lethabarb bottle would be strategically left on my consult table, adorned with stickers of my favourite colour, in the hope I'd do something that would shame the angry customer into leaving the clinic alone. (Ha, the joke would be on them. My one-handed venipuncture skills weren't nearly good enough.)

Jane had already warned me that my consultation write-ups were too long, but now I felt compelled to include even more details with which to defend myself in the event of a complaint. I was worried that, without support from my colleagues, such an event could wreak havoc on me emotionally. I had been lucky enough to have great clients in the short time I had been at the clinic. How long before my luck my ran out? A September 2017 article in *The Medical Republic* mentioned researcher Elizabeth Van Ekert's investigations into doctors' responses to complaints. Unsurprisingly, she found that many of them suffered from anxiety and depression during the process, and that some were ostracised by colleagues. She made the point that because medicine is a vocation, a complaint is also an attack on a doctor's very identity. There is no reason why this would not apply to veterinarians. You can't necessarily prevent unjustified complaints, if people are determined to make them, but supportive people can help create a shield to prevent those complaints from affecting your very identity. I didn't have such a shield, so I needed to make sure I was gone before any outside attack could be launched.

That afternoon, despite feeling a bit stunned, I wasn't fantasising about being hit by a vehicle on the way home from work. Everything was eerily calm. I felt that I could stop blaming myself for the unhappiness I was experiencing. If I was the clinic's primary problem, a straightforward solution presented itself immediately, and I didn't need to agonise over it any longer. The following day was a rostered day off, and I already had plans to meet a couple of people, but I now arranged to catch up with my official mentor, Carol, as well. I hadn't seen Carol in person in over half a year—she'd been dealing with a lot herself, undergoing chemotherapy on top of managing her multiple children amid the usual chaos of life—but she still made time for me and listened to my string of barely coherent words describing what had happened. She

wholeheartedly supported my decision to leave, even though it didn’t really feel like it was up to me. I thought of Kate McLennan's web series *Bleak*, in which the main character is asked to resign. She awkwardly attempts to explain her early arrival home by announcing to her boyfriend that she “got resigned”. Perhaps I was getting resigned as well.

The only part of it all that really bothered me was that I would have booked a longer trip away if I’d known earlier that my employers and colleagues wanted me gone. They’d clearly been planning this for some time, and they knew I was going overseas for the wedding. I’d deliberately limited myself to a two-week absence so as not to inconvenience anyone at the clinic, which meant that I wouldn’t have time to visit everyone I wanted to see. Some of that fortnight was already set to be consumed by travel time and recovering from jetlag. Even with the short-term special airfare deal I’d managed to find, the flights still cost about the equivalent of my fortnightly salary. Changing the return date at this late stage would be prohibitively expensive, as I discovered when I looked into it. This seemed like more than just an oversight on my employers' part and bordered on deliberate malice, but I couldn't be sure; being inconsiderate appeared to come so naturally to them that they may not have thought about it. Maybe Jane had been planning to tell me before I made the original booking, but I highly doubted it; I was quite sure that her desire for me to merely “look into” flights had nothing to do with wanting to forewarn me about being an unwanted employee before I entered my credit card details.

Jane seemed almost elated when I gave notice the next day. It was clearly the outcome she had been working towards in the review discussion. She expressed a willingness to introduce me to people outside the industry to ease my transition into a new career. I politely declined, being fairly certain that it was an insincere offer designed to show off the fact that she had connections (who would definitely have a low opinion of me after a gossip session with Jane), but seeing her happy in my presence for once was oddly satisfying. At long last I had succeeded in doing something that made one of my employers pleased with me. If I'd known, I would have made an effort to resign more frequently.

Chapter Eleven

The events of the preceding months had served to chip away at what little confidence I had in myself and the trust I'd initially had in my colleagues, until eventually my attitude of "I'd rather look stupid now than risk doing the wrong thing" was replaced by one of "I need to pretend everything is fine to avoid making life hard for myself"—an attitude greatly at odds with what felt comfortable. The hardest time was the month following my resignation. I was so convinced that I'd be thrown to the wolves if anything went wrong that I avoided doing anything practical whenever possible, and I didn't make any unnecessary disclosures. For the first time, I forgot to weigh a cat in a routine vaccination consultation, due in part to the client's hurry to be elsewhere. I'd normally be scrupulous about making a note of things like that, for the sake of maintaining an accurate record, but I knew that this was one of Jane's particular bugbears, so I simply put down a weight that was very similar to the previous one without being exactly the same. (It looked about right, and the client hadn't reported anything of concern.)

Once, towards the end of a surgical procedure, I was rearranging some instruments on my sterile work area before closing and noticed that the swaged-on needle was missing from some suture material I had used to ligate vessels. I plunged my gloved hands into the patient, hoping that they'd be sensitive enough to feel any sharps that may be loose. A torn glove was a minor problem compared to the gut perforation that may result if the needle remained there. I felt nothing. I repeated the procedure with swabs, and they came out progressively cleaner, meaning there were no bleeds. However, it still unnerved me that I didn't know where the needle was.

When Jane wandered into the room at around this time to look for something she needed and saw that my swabs were coming out clean, she remarked that she was satisfied there were no bleeds and that I could close. I wanted to ask her to double check, or to let me take radiographs, but I knew from past experience that any admission of concern on my part would be met with hostility, and the rest of my time at the practice would become unbearable. I desperately wanted to avoid conflict, so I said nothing. I couldn't even ask the nurse assisting me whether she had already disposed of any stray sharps (which at this point seemed the most likely possibility). The nurse was Candy, who had told Jane about the anal gland incident, and I had received several other indications that I couldn't trust her. Our employers had not made a secret of their dissatisfaction with me in the nurses' presence, starting but certainly not ending with the early comments about showing up for work with a cold. This appeared to have led Candy to the obvious conclusion that sharing negative stories about me would help to ingratiate her with our bosses and foster a sense of camaraderie.

I could hardly blame her for that, given that I now had first-hand experience of how difficult life could be for employees who were not part of the dominant clique. Not all the nurses were like that, of course. There were some with whom I was delighted to work, whose presence made me feel so much less tense and work so much more productively that I would have chosen their mistakes over a perfect technical outcome from an unsupportive nurse any day.

Unfortunately, I hadn't been assigned one of those nurses on this occasion, and I had to be very careful about what I revealed in Candy's presence. In the past, I had been quite comfortable talking to the nurses during surgery if I was concerned about something, as I had a high regard for their complementary skills and knew that I may need to ask them to bring in assistance, but I now realised this was a big mistake when nurses like Candy were around. Nurses may be more experienced than many veterinarians, especially new graduates, in most practical matters, and they may have assisted at identical procedures countless times before, but it turns out that most of them have no idea when something is wrong with the procedure itself, even when the problem appears blindingly obvious to the surgeon. Despite Candy's evidently low opinion of my clinical skills, I could tell that she would not have been able to understand what was happening in the non-nursing side of the theatre unless someone expressly pointed it out, and I could make my life much easier by taking advantage of that.

My anxiety for the rest of the day must have been apparent to everybody, like a flashing light on my forehead, and I was puzzled when nobody appeared to notice anything. As I walked home, the same two thoughts alternated in my brain: "It wasn't there; you checked so many times and there was nothing." "But where else could it have been?" I wondered what I'd do if it turned out to be there after all. Would I even be able to live with the guilt? I was so plagued by self-loathing that I couldn't even say anything to my boyfriend when I met him for dinner that evening. After the weekend, I left a message with the client to ask how the patient was. She'd been doing well since the procedure, apart from a minor gastrointestinal upset that resolved after the NSAIDs were discontinued. This possible NSAID reaction gave me an excuse to call again a few days later, at which point she was still completely fine. This was very reassuring, but it still failed to address the underlying problem: that I'd felt compelled to place self-preservation above patient welfare. And it was already paying dividends, because I didn't hear any snide remarks about my skills that week.

I became less supportive of my colleagues and less likely to stand up for them. Previously, if a nurse had done something the wrong way when I was the vet in charge, I hadn't hesitated to take responsibility. Did it really matter if I hadn't personally radiographed the a skull prior to a dental procedure if the nurse was doing it on my behalf? I wouldn't have been able to do a better job, so I didn't really care if the manager assumed I'd taken the radiographs myself and proceeded to show me how it should have been done. Another clinician forgets to sign the S8 book, or confuses left and right in the consultation notes? Perhaps point it out to them, if it's something that I can't quickly remedy myself. It's easy for that sort of thing to happen, and we're all looking out for each other here... That Pollyanna optimism disappeared once I realised these were taken to be passive admissions of culpability that were being tallied up and used against me. My under-a-bus-throwing muscles needed to be flexed.

I started to make a point of letting others know when I wasn't directly responsible for something, generally by subtle (or maybe passive-aggressive) means, such as admitting that I was too inexperienced to understand why someone had done something a certain way (i.e. the wrong

way) and needed someone else to clarify it. If I detected an error in the previous consultation notes, I would simply contradict it in my own notes, without informing the previous author, knowing it would make the latter look bad. They probably wouldn't notice it until long after my departure anyway.

I still refrained from broadcasting any errors made by nurses who were consistently supporting me, because I truly relied on and appreciated them, but what if they were also complaining about me in secret? It seemed likely, given the culture of gossip, but also unlikely, given that Jane seemed to want me to know how many people had misgivings about me. To have other names in the arsenal without raising them seemed almost wasteful. These nurses were also frequent subjects of gossip themselves, either for their lack of confidence or absences from work. That didn't preclude an active contribution on their part, of course, but they seemed to go out of their way to say nice things whenever possible, even about those who didn't return the good will. One of them even gushed about how great it was to work there, while other nurses were grumbling behind her back about a couple of sick days she'd taken.

On one occasion, I had a client show up half an hour late for a euthanasia appointment, arriving at the same time as the following client. I understood from the history that the euthanasia client was the mother of the person who had adopted the cat and that her daughter was working interstate. As soon as I saw her in the reception area, looking simultaneously flustered and dejected and surrounded by an improvised campsite of her cat's paraphernalia, I knew she was going to need a proper appointment rather than a rushed one. I suspected her emotional state had contributed to her late arrival. By contrast, the client who'd arrived on time was there for a quick follow-up appointment, and I knew from my previous interaction with her that she was the busy mother of a toddler and had probably rushed straight to the clinic from work. I approached the euthanasia client and calmly introduced myself, letting her know that I was going to quickly see the other client before getting to her. She smiled and thanked me. This kind of introduction wasn't my usual practice when I had clients waiting, but in this case I felt that the euthanasia client was someone who needed acknowledgement and human contact.

On this occasion, Candy was relieving the usual receptionist. As I called the recheck appointment in, Candy declared in an audible, appalled-sounding voice that the euthanasia client was my four o'clock appointment. I was irritated at this potential disruption to the equanimity I'd worked to create, as those words could have given the euthanasia client cause to think there was something wrong with the way she was being treated. Luckily, she appeared to be too absorbed in her own grief to notice.

"This is my four-thirty appointment," I replied in as firm and confident a tone as I could manage, indicating the clients I'd already invited into my room. After all, that was the current time.

"But that's your four o'clock appointment!" she shrilled. I dearly wanted to tell her that I had very good reasons for choosing this particular order, that euthanasia cases require patience and should not be treated flippantly, and that in any case, it was totally inappropriate for her to be

questioning my decisions in front of the clients. However, I knew this wasn't the right time. I simply repeated that this was my four-thirty client with a gritted-teeth intensity that I hoped would convey these things without explicit words, and I got on with my job.

As I'd predicted, the recheck consultation went quickly and the client was eager to move on to her next engagement (possibly collecting her son from daycare) once it was out of the way. The euthanasia client, by contrast, wanted to explain her situation at length, and she needed lots of assurance that she was making the right decision (which she definitely was). She even had her daughter on speaker phone from her interstate location, and the latter also contributed to the discussion. Both cried and bade their beloved cat farewell as I administered the lethal injection. It was a long consultation as they came to terms with what was happening, but I didn't feel rushed (knowing that my punctual client wasn't pacing back and forth in the reception area, waiting in frustration for me to finish), and I didn't want the clients to feel rushed, either. I offered the mother a chance to stay in the consultation room with the body afterwards while I arranged things elsewhere. Both mother and daughter thanked me profusely for my help, and I thanked them for adopting an elderly cat and giving her the best possible retirement. I had an affinity for clients who rescued adult animals and cared about them so much, so of course I was happy to do anything I could for these ones. This was yet another example of work being a refuge from my workplace, and these lovely clients had put me in a good mood. I still thought I needed to speak to Candy afterwards, but by then she'd been relieved by the usual receptionist, and I was too busy with other matters in any case.

However, this was my final month, and I was no longer in a frame of mind to overlook things that bothered me. This was particularly important in the case of Candy, with whom pre-emptive counter-undermining was a necessary strategy to avoid problems. When I arrived at work the following day she wasn't on the early shift, so I couldn't raise the matter with her directly, but her primary supervising nurse, Amy (who never missed an opportunity to sing her praises), was. While I was preparing for the day's cases, I casually mentioned to Amy that I needed to talk to Candy at some point, and proceeded to explain what had happened. Amy, as expected, was quick to defend these actions, even though she seemed to be struggling to think up justifications on the spot. "Yeah, but when you've got someone crying in the waiting room...." she began, and I detected a determination to twist the situation to one of Candy valiantly trying to save the day from the villainous Dr Dumbarse.

"Interesting," I thought. "She's heard about this case already." Candy had evidently rushed straight from reception to share the gossip about how dreadful I was for wantonly neglecting an upset client, and her audience had been quick to accept and share her harsh judgement. I calmly countered this with a reminder that euthanasia consultations are important to do properly, without rushing people through them, especially when they're upset. This was a difficult point to refute, as was the fact that openly contradicting a clinician in front of clients who are already upset is not very professional. The fact that Amy persisted in trying to think up excuses even then was very telling. At that time, an Oatmeal cartoon about the so-called backfire effect was being shared widely on social media, the premise being that even the most irrefutable facts are

unlikely to change a person's mind if they contradict deeply held beliefs that are at the core of a person's identity or worldview. Apparently, my incompetence was so entrenched in the minds of my colleagues that it had become part of their very identity. I could tell that Amy's worldview had long held that Candy was infallible and that my decisions were always wrong. It confirmed my suspicion that this wasn't about what I did or didn't do. It was about me. I had definitely made the right decision to give notice.

Chapter Twelve

While counting down the days until I finished, I also couldn't help mulling over the matters raised at the review. Points that at the time had seemed rather unfair now presented themselves as totally ridiculous, and as the weeks progressed the nimbus of indignant helplessness formed itself into a series of coherent sentences. I was finally feeling confident enough to communicate these sentences at an exit interview, but as my last day of work approached, I had not yet received an invitation to attend one. It wasn't until my penultimate day that I finally raised the matter with Michael in passing, calmly pointing out that he and Jane hadn't yet scheduled an exit interview. He looked slightly taken aback, asking if I wanted one. Without directly answering his question, I confidently remarked that it was good practice. He agreed, albeit in a voice that didn't project its usual steadiness. My demeanour and my career background in an office environment might have conveyed the impression that I knew what I was doing, while being perfectly aware that they had no idea.

The agreed-upon time for the exit interview was the following day, just after my only scheduled surgical procedure, at which I was assisted by a new nurse on her first day who was an absolute delight to work with but still didn't know her way around the clinic. As a result, the meeting started over an hour later than it was supposed to, and I was grateful that Jane and Michael didn't take this as an excuse to call it off entirely. The room was the same one used for the review a month earlier, but the mood was completely different. I wasn't surprised that they looked happy, given that I was leaving that day, but I had the impression their smiles were suppressing a hint of nervousness. Unprompted, Jane beamed at me, declaring that she wasn't sure what had happened in the past month, but my performance had improved beyond measure.

I was unprepared for this.

This positive assessment of my performance was utter nonsense. Even I wasn't deluded enough to believe that it was due to any particular skills I had suddenly acquired in the previous month, eager as I was to cling to any scrap of praise after having put in so much effort. Perhaps they wanted us to part on good terms. However, it was also entirely possible that they really did perceive a level of improvement beyond what had actually taken place. I had, after all, been less willing to ask for help when I needed it, possibly leading to a perception that I genuinely needed less help—when, in fact, I was extremely worried about potential negative outcomes and wanted nothing more than to be able to confirm things with someone I could trust.

My sense of self-preservation had driven me to avoid opportunities for practice or development. Venipuncture practice? No—the nurse can do it; I don't want a failed attempt to be a black mark on my record if it's a difficult vein. Helping to set up for an anaesthetic? Always a good skill to have, but it's safer to steer clear of it entirely than to risk needing to ask the nurses for assistance with one of the steps. I didn't trust myself to do anything much at all, lest it be added to the tally of failures if it didn't work out.

There is a quote usually attributed to Aristotle: "To avoid criticism: say nothing, do nothing, be nothing." In my current work environment, I decided to take this literally, as sage advice rather than a warning. My original aim at work was to learn as much as possible in a supportive environment, because I valued skill development over pay. Now that I understood how things really were, I became far more concerned about avoiding criticism. The earlier situation in which I had "panicked" during the induction simply didn't have a chance to arise again, because I stayed well away during inductions (which is what most vets at the practice appeared to do anyway). Ditto the pancreatitis test: with my new attitude, I would have asked the nurses to run it for me and left them to it, without asking them to talk me through it for future reference. If another vet was running behind on consults and I had a few minutes to spare, I'd make sure it would be an easy and stress-free case before offering to assist by picking one up, so I could keep my own requests for assistance to a minimum. I no longer annoyed the clinicians by asking if I could be present during their consultations; learning was lower down on my list of priorities than keeping a low profile. The missing needle incident was probably the most disturbing symptom of this desire to avoid looking bad, but by pure luck that had turned out to have no adverse consequences.

The Aristotle-inspired course of action had paid off. I may have been actively avoiding opportunities to learn, and challenging myself less than ever before, but to people who were attuned to dwelling on faults, and didn't value effort or enthusiasm (or even failure for its crucial role in learning), this was perceived as a vast improvement. This was not a total surprise. Many students worked out in our final year that you were more likely to pass a university rotation by keeping your head down and staying below the radar. Highly motivated students who complained about being used as free kennel hands instead of being exposed to genuine learning opportunities would be viewed unfavourably by many supervisors. Other students decided that it was far more important to just get the rotation out of the way and save the learning for when our graduation date would no longer be affected. My way of compensating for this when I started my job was to ask as many questions as I could about everything I was seeing, having taken my employers at their word during the interview that this was an attitude they fully supported. Unfortunately, it turned out that my attempts to learn were incompatible with making a good impression on my colleagues. All the questions and double (or triple) checking just made me appear annoying or stupid.

The other, and possibly more important, factor contributing to this oddly positive assessment of me was that I had become a more valued employee the moment I gave notice. It was apparent that nobody with any sense of self-respect would tolerate this kind of treatment. Therefore, by resigning, I suddenly became more respectable. I'd been trying extremely hard in this job, frequently turning up an hour before my scheduled start time so I could read through patient histories and learn as much as I could about the presenting complaints, based on a couple of typed words entered into the appointment slot by the receptionist, in order to feel better prepared when my consultations started. (I later discovered that this occasionally resulted in grumbles of complaint from the nurses who didn't realise I was not yet "on" and wondered why I

was sitting at the computer reading instead of doing real work.) This overeagerness probably resulted in an anxious, “desperate” aura that made me a soft target. “Willst du gelten, mach dich selten”, as a German saying goes: basically, you need to play hard to get if you want to be appreciated.

Perhaps being at an exit interview that I had specifically requested also put me in the more powerful position. Were they worried about the effect this might have on their reputation? Maybe it had dawned on them in the intervening period that I must have contact with other students from my university, which was a logical feeder university for a clinic in this location, and that if they themselves were capable of indulging in gossip, we were as well. Chatting to like-minded friends about challenging situations that have arisen at work is one of the most predictable ways of coping with those situations. Group chats on messaging apps make it possible to do this immediately after an incident occurs, without any need to wait until the weekend to cry over a drink. I may have appeared to my colleagues to be a solitary outcast in the context of the workplace culture, but I was actually interacting with my wider support network on a daily basis. If they’d considered that things they were saying and doing to me were being discussed in detail with potential future colleagues, I wonder whether they’d have considered their words more carefully. Possibly not, but I like to think there’s still a small chance they might have.

In reality, my friends and I were not terribly preoccupied with naming and shaming our clinics. Online group chats with different people from uni ran hot with reports of difficult bosses, unreasonable clients, cute patients and—most of all—general embarrassment over our lack of knowledge and the foolish things we found ourselves doing in the course of our work. We were far more interested in our own feelings and supporting each other than in bringing anyone down. We would have ended up in a padded cell otherwise. However, we still kept tabs on where everyone was working and why they’d quit, to the extent that a friend who graduated after I did turned down a job with a great salary and the perfect hours for him because he’d heard too many negative reports about other vets’ experiences at that practice. In my own case, I had already indicated that my next role was unlikely to be a clinical one, so I would not be requesting a reference from them, but future applicants for positions at their clinic might well seek information from me (which, indeed, a couple of them subsequently did). Had I finally ended up on the right side of the power imbalance?

The positive reports of my clinical performance continued throughout the interview. Somehow, my previous failures had now turned into successes. When I started to bring up the dog with hypoadrenocorticism whose case had formerly been used to attack my clinical skills, I couldn’t even finish my first sentence before they interrupted me to let me know how well I'd handled it. Clearly, nothing about my handling of the case had changed in the preceding four weeks. All the recheck appointments had been done with other clinicians, somewhat to my disappointment, because he was an exceptionally cute dog with a lovely disposition (and also because I was missing my only opportunity to learn about the management of this condition). Similarly, the unforgivable sin of taking the temperature after expressing the anal glands was no longer an issue. Jane now justified her previous dressing-down of me in terms of only wanting to help, as

I'd just described the situation to her to explain why I was in the treatment room in the first place. She thought this meant that I'd been asking for her advice, and she was surprised when I didn't take it. Er, so her feelings had been hurt? This seemed unlikely. Apart from that, she didn't have any problem with what I'd done.

Jane actually went so far as to tell me she owed me an apology following a disagreement we'd had many weeks earlier over the standard spelling of a common procedure's name. I didn't understand why were arguing about it at the time, given that the answer could be found in the dictionary. Well, it seemed that she'd actually looked for herself, probably in an attempt to prove me wrong, and had discovered she'd been making an incorrect assumption for decades. This was the only evidence I'd seen that Jane was capable of changing her hardened views based on the available information, although she'd waited until we were behind closed doors to make the revelation. How strange that her predilection for discussing matters of contention with me in front the nurses did not extend to this concession.

Jane and Michael then mentioned that they'd tried to remember what it was like to be a new graduate. It sounded like they were hinting that I may not have been so bad after all, and that I only appeared that way because they were so far removed from the situation. This didn't sound like the sort of insight they would normally have. Had they been talking to a workplace psychologist or one of their switched-on friends from a different clinic? Had they attended a seminar of some kind? I decided not to ask.

They even seemed interested in hearing my opinions. They asked whether some of the specific things they'd done had helped me as a new graduate—things such as observing a couple of consultations with one veterinarian in the first week before heading out to do them all on my own. To be honest, those things hadn't really helped much, because there hadn't been any logical structure to them, but I was too surprised and unprepared to provide a proper answer; I hadn't thought about all of that as much as I had about other matters.

What I could tell them was that their behaviour towards me in the nurses' presence had affected my relationship with them, and consequently, my ability to do my job. In the spirit of positivity they'd adopted at the beginning of the interview, they agreed that nurses are important to veterinarians, particularly to new graduates. Jane explained that she'd expressed her disappointment at my coming to work unwell because someone else had told her I'd refused a previous request to go home. The veracity of this statement was highly dubious. For one thing, Jane hadn't brought it up when I'd first raised the matter with her privately. Additionally, I'd discussed Michael's refusal to let me leave early with the other nurses that day. Not a single one among them had misunderstood. I could have asked who exactly had given her such patently untrue information, but that would have been disingenuous. If she'd invented the justification in an attempt to repair our damaged rapport, I decided it would be unwise to rock the boat, especially as I was hoping to take advantage of their uncharacteristic receptiveness to feedback by using the example of Candy's behaviour at the reception desk on the day of the cat euthanasia.

“It’s always difficult when you need to make decisions and there’s a euthanasia involved,” they said, or something to that effect. I replied that it hadn’t been difficult at all; this was precisely the point I was making. It was one of those rare occasions on which I was confident about what I was doing and why I was doing it. I had actually assessed the situation well: the client who was on time was visiting for a quick retest that didn’t take long; the client who was late was prepared to wait, and may well have arrived late in the first place because she needed additional time to process the situation. The client had truly seemed to appreciate this and stated as much, as did her daughter on speaker. The outcome was a good one, or as good as could be expected for such an upsetting situation. I didn’t press the point further. My managers’ capacity to re-evaluate established views could only be stretched so far, even when they were in a good mood.

The meeting ended on a high note and we got on with the day. Amy had made one of the impressive experimental cakes for which she was famous, incorporating some of the chocolate chips I'd given her by way of a research grant. Jane had brought her extremely lovely dog into the clinic, telling me she'd done this for my benefit as she knew how fond I was of him.

I discovered that quite a few people hadn’t been aware of my impending departure until the token farewell card was passed around for them to sign the day before. I had assumed they were avoiding the discussion out of politeness, knowing full well that I was leaving due to a general consensus that my performance wasn’t satisfactory. It seemed odd that the principals wouldn’t inform the small team of such a major staffing change, even in light of the abysmal communication that had been a defining feature of my time at the clinic. Dr Kim, evidently having heard about it very recently, farewelled me with a perfunctory hug and said she was sorry that the job wasn’t what I’d expected. The words she spoke, and also the ones she omitted, spoke volumes about her low opinion of me. She evidently believed it was clinical practice itself to which I was not suited. By contrast, I’d had a whole month to think and talk to others about what I’d been experiencing, and what I liked and disliked about the job. I was learning that there were so many things I loved about the work, and so many more things I wanted to learn, but that my current situation was inconsistent with that. I was also finally starting to believe the stories I heard from other new graduates that nearly all of us were feeling equally incompetent.

Chapter Thirteen

This can be a very challenging and draining profession. You need to manage physical risk, emotionally charged cases, abuse from clients and the constant anxiety that comes from wondering whether your treatment plan is really the best one. These things are going to exist no matter what sort of work environment you have, and they will always make life challenging, but they can be manageable in the presence of a supportive team of people who want to help you to remain positive.

I'd like to be able to say that what kept me going through all of this was my commitment to the patients, but it was really my contact with former classmates: the recent graduates and almost-graduates who could relate to what I was saying and share their own stories. I was fortunate to have been in a good sub-rotation group when I worked the notorious after-hours shift at the university clinic as a final-year student, and we kept in touch through a chat group, in addition to the year group's private social media page and separate group chats with different uni friends. After a casual prompt one day, the social media page rapidly became filled with accounts of the embarrassing things everyone else had done, from incising on the wrong side of a ligature during a castration to moving the decimal point and administering ten times the recommended dose of morphine. Advising a client to administer NSAIDs when the patient was already on corticosteroids seemed to be rather common. (I should mention that these particular cases all had good outcomes.) It seemed that everyone had at least one story to tell, and those with a reputation for being stellar students appeared to have more than most, possibly because they were simply doing more. It was obvious that if everyone who'd made a serious mistake was encouraged to seek a career elsewhere, we wouldn't have any vets left, least of all the especially good ones.

It was apparent that many other new graduates were dealing with the same problem of being given insufficient mentoring and involvement in non-routine cases while still being expected to somehow become more adept at handling those cases—as though the mere passage of time equated to more experience. The established vets didn't want them in the way during a chaotic emergency, so the first they'd see of that kind of emergency was when they had to manage it independently. Unsurprisingly, this did not always produce the best results. I noticed when I was applying for jobs that some practice owners, desperate for staff and unable to find anyone more experienced, tried to sell sole charge to new graduates by appealing to our sense of pride. If we don't think we're ready for it, this means we're scared of taking responsibility: we're not proper go-getters, prepared to throw ourselves into the deep end and think on our feet. We're all just babies wanting our hands held! Whatever. My patients' safety is more important than my ego. We're not talking about an immersion language class here; the work we do is far too important to rely on bravado. The consequences of faking it can be dire. An outward display of confidence may add to your social capital at work, but at what cost to the patients? The truth is that I want to be cautious. I want to feel that I'm actually doing the right thing, instead of pretending to be doing the right thing. I want confidence to come from genuine ability, not an inflated sense of it.

In a way, I was lucky in that I'd already spent time in the workforce, in different industries. I knew that it was possible to move from one team to another in exactly the same workplace and have a totally different experience, demonstrating that I hadn't been the problem after all. Yet despite knowing this, I couldn't help hating myself for being at fault when I didn't feel that things were quite right, at least before the final month when I was able to assess the situation with more clarity. An astonishing number of other graduates from my cohort were going through the same thing I was at work but wouldn't have had prior experience of positive change. We all reassured each other, even in the case of people who hadn't particularly liked each other at university. Whatever our differences may have been, none of us deserved to be treated that way.

My relief at leaving the clinic might confuse some veterinarians, as everything was fine on paper, at least in terms of working conditions. My hours there were good, for one thing. It's true that the slightly unpredictable finish times made it difficult to participate in regular, scheduled activities after work, which wasn't great for combating social isolation, but I started later and finished earlier than a lot of people in the industry (and the possibility of working non-standard hours was actually one of the things that had attracted me to it in the first place). Because of my longer consultation slots, I rarely needed to do overtime. I also got out of working on weekends for those four months—it was such a small clinic that there was only one clinician rostered on for the Saturday morning shift, and I was not yet experienced enough for that clinician to be me. Another thing that is regularly cited as a reason for burnout in the profession is the attitude of clients, and my clients were fantastic, so I had very little to complain about there. I'd endured worse conditions as a uni student, when I was working hard with no pay.

Others may wonder why I didn't simply learn from my experience and permanently adopt the behaviour that so impressed my bosses in my final month. I'd worked out that avoiding learning experiences, fabricating information to fill gaps, undermining colleagues and failing to disclose potential errors was the way to succeed there, and I could probably have applied these strategies to a new workplace for guaranteed success. However, that wasn't going to give me any job satisfaction in the long term. I didn't want to leave work every day hating myself.

Good working conditions on paper are important, but the attitudes of colleagues make the biggest difference. Many people in the industry seem to view tolerating a toxic workplace as something of a rite of passage. This attitude is reinforced by the weaponisation of the term "resilience" to disparage anyone who raises an objection to bad management. Vets are said to be lacking resilience if they depart from a bad clinic or leave the industry altogether, while workers in other professions are applauded for trying to better their situation with new opportunities. Interestingly, the established clinicians who talk about resilience only seem to apply it to the vets who object to being mistreated at work; it's rarely presented as a goal for practice owners and other workers who need to learn to manage their stress without using other staff members as emotional punching bags.

To me, the idea that vets build character by tolerating a bad workplace is flawed thinking. A clinic that makes veterinarians feel constantly on edge has to be detrimental to the clinical decision-making process. Perhaps this is less of a problem in the case of experienced clinicians for whom most of the cases they encounter resemble “two times two” problems, but for new graduates, nearly every problem is a new one, and the ability to think clearly and logically is critical. The best supervisors we had in final year were the ones who, despite the demands of their work, never took their frustrations out on the students or interns. One of them had chosen to specialise in one of the most stressful fields, but he seemed perpetually relaxed, even when he was working hard to thwart his patients’ most determined efforts to die; he pensively chewed gum while taking in what was happening and working out what to do about it. He also managed to find something positive to say about every one of us at the end of the rotation. He explained to us that keeping one’s cool in an emergency is critical, because yelling and snapping at the nurses and other veterinarians is going to make them flustered and impair their ability to work effectively. A culture that accepts this kind of behaviour as normal is not just bad for us; it also presents a danger to our patients. If we aren’t trying to do the best thing by our patients, why do we work at all? It’s certainly not for the money or lifestyle. Viewing the toxic workplace issue in terms of patient welfare, rather than worrying about the "special snowflake" label, may help us to stand up for ourselves.

Chapter Fourteen

I made the decision to take a break from clinical practice. Despite the strong belief that better management may have helped me enjoy that type of work, I still couldn't shake the conviction that my bosses were correct in their assessment that I was just useless at the job. It was difficult for my friends' protestations that I needed to view it as a one-off bad experience to convince me that much would change if I worked at a different clinic. Reputations are made rapidly in this profession, and the good employers (or even the not-entirely-terrible ones) can afford to be selective. I was fairly convinced, channelling Groucho Marx's famous quote about not wanting to belong to a club that would accept someone like him as a member, that any clinic prepared to employ me must be dreadful.

Besides, I reasoned, I probably couldn't find another clinical job even if I wanted one; they would want a reference from my previous employer, and my experience of overhearing the phone call about Laura the temporary nurse provided a fairly solid basis for my conviction that only unpleasant things would be said about me. Even if I didn't list these employers as referees, the vet world is so small that an informal reference might be sought in any case. I figured it was probably best not to throw fuel on the fire of damaging rumours by encouraging other people in my industry to seek them out. (I later found out that I needn't have worried. Employers in this industry are so desperate that they rarely seek references, and would probably ignore them if they did, given that many of them had similar experiences to mine as recent graduates. The fact that an applicant is still legally allowed to practise is recommendation enough.)

It should be said that there were plenty of things I really liked and respected about this clinic, and I was grateful that I was even offered a job in the first place, even if it was only because at least one of their preferred applicants had turned it down (as I found out through my network). It's also true that many of my friends had much worse graduate experiences than I did. I often only discovered this later, such as when I overheard one of the most driven students talk about workplace bullying so relentless that it had contributed to a physical illness. Having only seen her upbeat social media posts from the preceding year, I had assumed everything was fantastic. Another of my friends—highly intelligent but averse to conflict—recounted episodes from work in our group chat that were so obviously examples of being pushed around and undermined. Having distanced myself from the industry by then, I couldn't believe she would tolerate such behaviour, almost forgetting that I had as well. Then there were other, far worse, stories I heard about people I knew in passing or didn't know at all. My clinic was practically an employer of choice by comparison.

Around two months after I left, I noticed that they were advertising for another new graduate. It was not a position for any veterinarian, with new graduates welcome to apply, but a graduate-specific position. This made no sense to me. Surely I was the failed experiment that made it clear to them that a new graduate was not suited to their needs? It's true that some new graduates (such as those who have had very proactive final-year placement supervisors) are able to do a lot more a lot earlier, but those graduates should be able to command a higher

starting salary than the graduate minimum they were offering—I had turned down jobs offering more than the pitiful minimum wage because I didn't think I was able to perform at a level to warrant that yet, and I valued experience over remuneration. Were they trying to save money by employing someone cheaper? That seemed to be false economy, given what I had been told about the early costs associated with employing a new graduate relative to the gains. Or perhaps they wanted someone relatively malleable who wouldn't have their own opinions?

I will probably never know the answer to this, but I certainly hope the next graduate employed there had a better experience than I did. When a couple of friends asked me about the clinic with a view to applying for the position, I made a point of not talking the place down, mainly to avoid making myself look bad. I stressed that the hours were good and the clients were lovely, and that I left because they didn't think I was very good. They read between the lines, though. Self-aware veterinarians know what it's like not to feel good enough, so they'll assume they're going to experience the same problems.

To potential employers outside of the veterinary sphere who asked me why I wasn't seeking another job in the industry, I assiduously avoided anything that could be perceived as badmouthing, because I needed to appear professional. To get around this, I usually cited the emotional burden of discussions about money and clients' inability to afford gold-standard care. This wasn't entirely untrue, because few vets really enjoy asking people for money, but I didn't mind it as much as I made out. By giving them this answer, I think I was hoping they'd spread the word to their friends that they should stop complaining about greedy vets, because we could make more money doing something else.

I also sometimes mentioned that it's a dangerous profession, which is also true. On more than one occasion I was genuinely worried about my bodily integrity. There was the cat with an abscess whose scratching paw narrowly missed my eye (when Jane pressured me to treat without sedation because the clients couldn't afford it); the huge gash in the arm of one of the nurses, courtesy of a different cat; the dog who almost bit me and the assisting nurses while I was managing another abscess (again, because the client hadn't wanted to pay for the sedation that could have spared us); the fact that the former head nurse was resigning due to a workplace-sustained back injury that rendered her unfit for any physical work… When you put your body in danger every day for a limited financial reward, you need to know that there will be a tradeoff in the form of some degree of job satisfaction, which is hard to achieve when you feel how strongly your colleagues despise you.

As a way of taking a short break, I ended up finding an office temping job on a two-month contract. At the initial informal interview, my future supervisors apologised that they could only offer me a low starting salary. I cheerily let them know that their offer was $500 above my previous salary as a recent veterinary graduate. As it turned out, I was moved up to a higher pay grade a couple of weeks later when another employee left to pursue a career more closely aligned to her degree, creating a gap that our supervisors immediately nominated me to fill. In

this low-level admin job, I was already financially better off than I would have been had I stayed at the clinic.

However, it wasn't the higher pay that most appealed to me about this job. It wasn't the flexible lunch breaks and abundance of local places in which to spend them. It wasn't being allowed to wear a jacket on cold days. It wasn't never being bitten or scratched by a patient. It wasn't being able to avoid the relentless questions about my work at family gatherings (because nobody wanted to hear more about how my office admin job was going). It wasn't even the guilt-free sick days, socially conducive finish times or adequate bathroom facilities for the number of women on each floor, although those were all positive points.

The reason I liked this workplace was that my colleagues were actually nice to me, something I'd almost forgotten was possible in a job. Staff turnover in this team was high, mainly because people would be moved to better-paid roles in other teams once they had settled in, and this turnover provided me with an opportunity to meet a lot of brilliant people with varied skills and experiences. Even though there were many things I didn't do perfectly, especially at first, the people I worked with were invested in trying to build up my skill level to help me contribute to the group effort, and they appreciated my willingness to learn. Nobody was trying to undermine me in order to look better. Some of our clients were dreadful, especially when we had a switchboard shift; there were many abusive calls, a few of which needed to be escalated. However, these could be brushed off after we'd groaned and laughed about them to the person at the next workstation. My two-month contract was extended by another few months, until I was on year-long contracts and wondering how I'd ended up there for so long when this had started out as a career hiatus.

I still missed the clinical aspect of veterinary practice, and I was keen to learn how to do things I hadn't yet had a chance to master. I was so eager to volunteer or shadow other veterinarians for free in my spare time that I even resorted to asking some of the recruiters who were perpetually determined to get in touch with me. They would send me repeated messages about the positions they needed to fill, presumably to receive their fee for fulfilling the promises they'd made on their websites to supply clinics with "experienced veterinarians" (which in practice meant trawling through social media for any idiot with the merest hint of a qualification). I was hoping they'd see it as an opportunity to cash in if the shadowing turned into a paid position. I assured them I had my own insurance organised, but this didn't seem to be very fruitful; it was paid work or nothing.

On a couple of occasions I looked into some of the numerous paid jobs that were advertised, thinking of easing myself back into the industry with a day or two a week while I still had the security of my office job to fall back on the rest of the time. Some of these advertisements seemed to be simultaneously desperate for applicants and desperate to drive them away. (One of them included "healthy" in its list of desirable attributes, to the amusement and horror of my friends when I shared the link in our group chat. Our translation: "Don't you dare think about taking a sick day.") However, the clinics prepared to employ a graduate only wanted a full-time

worker, and I wasn't prepared to give up the job I already had to risk returning to what I'd endured before.

Eventually, I started losing the clinical knowledge and skills I'd already developed, and sometimes I had trouble believing I'd ever known those things. And had I actually performed surgery?

In my case, feeling useful is the most important thing in a job: I need to know that I'm making a positive difference. I've noticed that humans have a remarkable capacity to endure danger, meagre pay and gruelling conditions if they feel that they're making an important contribution to something they believe in. I strongly suspect that the inevitable challenges of the work itself aren't the primary reason so many of us have been dissatisfied with the profession and ultimately left it. We can handle many of these challenges if we're also feeling supported, at least emotionally if not practically. It's sad—for the individuals and for the profession—that so many veterinarians aren't receiving that support.