A parallel consult

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All patient details have been de-identified, and pseudonyms have been used.

The day before I met Larissa, she took the 56 tram back to her apartment after finishing her first closing shift at the cafe run by her childhood friend Roberto's uncle. As she passed the newly familiar faces of her neighbours milling around the entrance to her building, she glimpsed her phone light up from her handbag. Suppressing an irritated sigh as she read Roberto's second text of the hour inviting her out for drinks with his friends, Larissa thought wistfully of her planned night of laundry and takeaway biryani from the Indian place downstairs. But she'd only moved to Australia a month ago, and certainly did not yet have enough friends to appear ungrateful to her sole contact from home. No matter, she reassured herself, she would put her uniform for washing and be back home in a couple of hours to start the dryer.

Walking into the local Irish bar thirty minutes later, Larissa was pleasantly welcomed by an atmosphere of warm camaraderie maintained by the after-work crowd. She sighted Roberto's slick black hair tilted back in laughter in a circle near the end of the bar. Upon approaching, he handed her a cider, appearing pleased with himself for remembering her drink of choice. She recalls the sweet, cold liquid on her tongue as she settled into her bar stool.

This painstaking account of Larissa's evening was told to me during a Friday morning of parallel-consulting during my fourth year GP rotation. The consults had so far comprised largely of repeat blood pressure medication scripts and snotty, congested babies, all presentations which fit nicely within my wheelhouse as an eager but overcautious medical student with an average rate of 45 minutes per patient. Larissa Diaz, a 26-year-old female presenting to the clinic for the first time, was next on my list. As the routine of the morning went, I planned to take a slightly overzealous history, followed by an attempt to take the patient's blood pressure without catching her fluffy cardigan in the velcro, before deferring to the GP I was shadowing to triple-confirm my tentative suggestions for management.

Larissa had barely sat down in the spare consulting room from which I was operating before decisively stating that she required an STI test. Mentally grasping for the phrases we'd been taught to conduct a sexual health history which normalised and encouraged safe sex practices – rather than revealing any of the uncertainty or awkwardness I honestly felt – I clumsily opened with a chirpy "Oh, great!" Checking my overly bright tone, I more calmly continued, "Do you have any symptoms at the moment, or is it just a general screening test?"

Larissa quietly responded that she had some pain. Feeling more comfortable as we entered familiar territory, I began to run through the classic pain profile questions. However, Larissa's curt responses seemed to suggest that a description of the alleviating factors of her pain was not the most pertinent detail for me to elicit, although I wasn't perceptive enough to clue into the direction she was trying to lead me in. That is, until she interjected to request that I also perform a pregnancy test for her. Feeling increasingly out of my depth and wishing that my articulate GP would join us in the room, I was scrambling to find a tactful way to ask about unprotected sex when Larissa continued, " I don't remember anything from last night."

With that I was really at a loss for what to say. So, I said “Okay.” And from there, Larissa began to, almost defensively, explain the very run-of-the-mill beginning to her night. I timidly interrupted to explain that although I was grateful that she felt comfortable sharing her story with me – grateful being a wholly inaccurate descriptor for the guilt I felt at being so automatically granted an entirely unearned position of authority and trust in the eyes of this vulnerable patient – she would likely have to repeat some no details to the doctor, and would she like to wait for the (actually qualified) medical practitioner to join us? Seeming to have barely heard me, Larissa said it was fine and continued to bluntly recount her confronting recollections from that night.

Her first visceral memory following the cider is waking up to a violent coldness. She described an absolute sense of disorientation which quickly dissolved to panic and nausea as she looked down at her naked body lying on unfamiliar sheets. Following the cold came a sensation of aching pain, over her wrists and abdomen. She felt a stinging and uncomfortable trickling of fluid between her thighs – a brief grimace darkens Larissa’s mask-like expression as she recalls this particular detail.

The dark shape gently breathing next to her started to take on a recognisable form, as did the broken bedframe on which it lay. Trying to regulate her breathing as she battled against the mental fog preventing her from accessing any explanation or context which might ease her mind, Larissa felt another wave of light-headedness as her hands grasped bedsheets instead of her phone. Sitting up lightly so as to avoid waking Roberto, she sighted her clothes strewn over his gaming chair in the corner of the bedroom. Shivering as she escaped the tangled covers, Larissa was relieved to feel the comforting weight of her phone in her jeans pocket as she dressed quietly. In the Uber home, she began to cry; she tells me this must have been because she was so drunk, as she couldn’t imagine what else would cause such a reaction.

Larissa pauses with her story and looks at me expectantly. Her words were delivered with such a numbness, almost a clinical detachment, that the only way I could think to respond was with a similarly objective sequence of follow-up questioning. How was she feeling now? She wasn’t sure. What did she remember drinking? After the cider, she didn’t know. Was there a chance she could have taken - or been given – any illicit substances? Maybe, maybe not. With every uncertain answer, I felt more and more awful for forcing Larissa to confront her memories, or lack thereof. I punctuated every question with assurances that she needn’t feel obliged to speak to me if she would rather wait for the doctor, which I retrospectively worry came from a selfish place of wanting to hide from her candour rather than out of concern for the patient. I was desperately trying to walk the line between providing a space for Larissa to share and debrief, without contributing to the trauma she’d already endured. But somehow, I couldn’t bring myself to leave her alone in the room while I brought in the GP, even though I have to think he would have handled the conversation with more grace and tact.

The first noticeable expression of anger I saw from Larissa was when she revealed that Roberto hadn’t replied to any of her messages or calls all morning. But this anger was short lived, and I will never forget how fragile Larissa sounded as she confessed her most underlying anxiety – “Maybe I wanted it.” The mask she had been so resolved to hold together for the last ten minutes suddenly fragmented in front of me as she exposed her shame at not knowing what she had taken, or what she had “asked for”, or whether she had “hurt his feelings”.

Right then, every single one of the tens of acronyms we’d been taught in our tutorials for approaching difficult conversations, where we light-heartedly followed exam guides to explain to our friends what a

mammogram is or outline the management of HIV, entirely escaped me. As it happened, the only phrase I could think to say was “What an asshole.” What a spectacularly inadequate summation of the burning sensation in my chest, whether it was from fury or helplessness or sorrow, for this woman whose sense of self had been wrecked by someone who wouldn’t even return her texts.

It was then that the GP joined the consultation, and I was able to sip water to soothe my dry mouth while I observed his professional, calm compassion. He brought such distinct kindness to the conversation with Larissa about her next steps that she began to cry, and I was embarrassed to feel tears threatening to spill over my own mask.

But at the doctor’s mention of the option of a forensic examination should Larissa wish to file a police report, she blanched. “What do you mean ‘report him’? He is my friend, I just need to talk to him.”

“Okay. Still, I think it would be a good idea for us to do a quick examination here, since you are in pain.” Noticing Larissa’s frame recoil back into her chair, the GP suggested that he check if one of his female colleagues was available to assist.

Left alone with Larissa again, I tried to make eye contact with her, but she stared determinedly at the cup of pens sitting on the doctor’s desk. ”God, I have to wash my clothes again, they were sitting in the washing machine all night,” she muttered to nobody in particular. Her reference to such a menial chore was a jarring but understandable attempt to reconcile her day with a semblance of normalcy.

The Royal Australian College of General Practitioners’ guide for management of a patient presenting following a sexual assault states that “most healthcare workers” believe they are “ill-equipped” to respond to disclosures relating to sexual violence. Beyond the status of healthcare worker, I felt remarkably incompetent in my response on merely a human level. Despite four years of medical training, where I memorised matrices of rare conditions and rehearsed examinations until they were muscle memory, never had I received a tutorial on how to guide another person through the worst day of their life. Upon debriefing with my GP, he encouragingly told me that these unteachable skills will reach me in time, but I cannot visualise any amount of time or experience which would allow me to hear Larissa’s story with any less horror or speechlessness. And I’m not sure whether I really desire that level of resignation to cruelties our patients endure.

What I am beginning to suspect - although I think any claims to a major epiphany should be reserved for once I have at least begun my medical career – is that maybe what patients seek from us as clinicians is a reassuring presence drawn in broad strokes. Behind the desk they see an equanimous, all-knowing figure in a white coat, irrespective of our actual abilities to produce a magic eraser and reverse their plights. And for some, I hope, maybe it is the gift of an unjudging ear which, if not curative, may provide some relief. Perhaps with our abundance of time and naivety, this is the role the medical student can fulfil.

Time, coupled with reflection enabled by discussions with my wonderful GP and insightful medical student peers, has allowed me to appreciate the privilege Larissa granted to me by using my consultation room as her temporary place of solace.

Two weeks later, the GP told me that Larissa had scheduled a telephone consult the previous evening. She had requested her medical records and a consult summary. She had apparently asked if she could speak to the medical student, and on hearing that it was my day off, Larissa asked the GP to tell me that she had decided to file a police report against the “asshole”.