Megan Torpey

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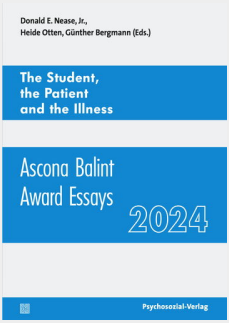

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It's OK, Gary. I'll Listen to You.

Megan Torpey

It was a freezing evening, wet and more miserable than usual in late June. The day had dragged, and I wanted to go home. But I also wanted to see surgeries, so I stayed despite my empty stomach and the dull ache niggling in my temples. "Just another Friday night!" the registrar responded with a shrug of his broad shoulders, unphased. The shouting increased in volume, then a loud thud. Our team walked, with pace and intention, around the corner. There, was a man.

On the floor, surrounded. Pinned.

The Emergency Department waiting room is never a comfortable place to be. It houses the desperate as they rock prams back and forth, tired and frustrated from the long hours of waiting. It has a certain smell about it, a mix of antiseptic and the unwashed flesh of waiting patients, slumped in cold, hard plastic chairs. "Oh Jesus, It's Gary again", the intern doctor mumbled. I slowed my steps in sync with his so that I could discretely whispered: "Who's Gary?"

Gary was a young man who looked much older than his years. He was local to the area and known throughout the hospital by association to his many family members and their collective complex medical ailments. Gary was a proud Indigenous man, which he would tell anyone who stood still long enough to listen. Though when he did this, it seemed to anger the staff and jolt the security guards into action.

Tonight, Gary swore and begged in frustration, "Test me!", he yelled. "Go on, just test me. I'm sober! I need a doctor". Gary didn't look sober. He was covered in vomit and smelled offensive. The undeniable stench of faeces surrounded him, to which the staff responded by creating barriers between themselves and the polluted man. Disposable, yellow cloaked barriers of personal protective gowns, but barriers non the less. These physical indicators of otherness glared obviously in the

stark grey gloom of the Emergency Department corridor where Gary had been ushered, away. The staff chose to unnecessarily wear multiple pairs of plastic blue gloves, one nurse sniggered to another as he "joked", "put on the whole box", which signalled a type of warning to those of us that could feel the separation and sense the imbalance hang in the cold night air. It was a public space by definition and occupation, but the unspoken words of unwelcome repulsion permeated the silence.

And Gary knew this. He knew it to his core.

The scene was one of complete disconnect. A dark-skinned man, in a colourful polyester t-shirt, lay, face down. I remember the recognisable dot print design of his garment and felt my objection to its loudness. Was I experiencing a profound sense of discomfort at the pride in which he proclaimed his identify? Or what I experiencing a sense of disconnection to mine?

I couldn't tell, but it bothered me. It was hard to look at.

Gary's arms were held tightly behind his back, forcibly restrained by the knee of an obese security guard. The staff huddled nearby in discussion, speaking about Gary, but not addressing him directly, which frustrated him further. He raised his head straining, face cocked laterally to gauge his fate. To which he was met with a mean jolt in the back of his lumbar spine. "Stay down, you black bastard", the guard spat. My whole body tightened in disbelief. Staring, shocked by the guard's blatancy, I held his gaze unintentionally. He softened his expression as our eyes met and plainly asked me, "what?" I didn't respond. I couldn't.

Later, for no apparent reason, the two security guards flanked the row of plastic chairs where Gary rested, eyes cast down. My team continued to huddle away behind the glass, separated from Gary, still. His eyes brimmed with tears, he clutched his gut, clearly in agony. I moved closer and bent down to greet him, breathing through my mouth behind my mask I winced at the stench.

"Hi Gary".

"If they've sent ya to send me home. I'm not goin'", he declared firmly but quietly.

"No, it's fine, I'm not sending you home", I said.

I cleared my throat, "My name is Meg, and I'm a Medical Student.

I was wondering what has brought you into hospital this evening?"

"I'm in pain", he groaned, pointing to his stomach.

"Can you tell me some more about this pain? Where it is specifically? Does it move anywhere? Does it come and go? Is it sharp and stabbing or dull and achy?"

He stopped, not quite knowing what to do, wary.

"No one cares, they don't listen" he protested.

I encouraged him gently, "It's OK, Gary, *I'll* listen to you". And with that,

Gary told me everything. He'd been in pain for three days and nights. Vomiting, and embarrassed to say that he knew he smelled repulsive. "The vomit is green and brown and smells like …", he trailed off, humiliated. "It's OK, Gary", I laughed a little, meeting his eyes in a moment of human connection, "I can smell what you mean, you don't have to say it". We laughed together and he reached out his hand. I accepted the gesture, momentarily holding his palm in mine. The security guards moved quickly to separate us. "Sorry, I'm so sorry", he offered. Upset with himself for expressing vulnerability. He stiffened his back and readjusted his blanket tightly around his forearms, securing a type of armour.

"Please don't apologise", I said as warmly as I could.

Can I please have a little look at your tummy?" I asked. He replied by lifting his shirt to reveal an enormous, distended abdomen. I thanked him quickly. And left, telling him that I would be back soon. "Don't eat or drink anything", I called back in an afterthought.

I hurried to my team, catching the eye of my intern, I motioned with my head. He stepped back from the inner circle of blue scrubs. "What's up?", he asked quietly.

"Gary's pretty sick", I stated. Which surprised even me. I didn't recognise the boldness I was showing, "he says he's not drunk; he has a three-day history of worsening crampy pain in his lower abdomen associated with multiple bilious vomits. He hasn't opened his bowels in over a week but reports a watery trickle of diarrhoea, he also says that he feels gassy and bloated but can't fart. He has tried to relieve the pain with Paracetamol, to no effect and other than his smoking history has no other salient findings. Gary isn't taking any medications and has no known allergies. Upon examination he has a significantly distended and tender abdomen with no bowl sounds present on auscultation".

Without looking at me, the intern pivoted and stepped back into the navy-blue circle of bodies with one determined stride. "I suggest that we take Gary for a quick scan, he has an acutely distended abdomen with a three-day history of …" he continued confidently, with my summary of findings. I wasn't surprised by this blatant lack of acknowledgement, by now I accepted the hierarchy of information sharing and other hospital-based practices.

"Ok", declared our consultant. "It's not busy. Take him."

"Can I please come?" I piped up, moving forward, making myself known. I was keen that Gary should have an ally. My intern accepted in an unsaid gesture of repayment for my history taking efforts.

* * *

"What's that?", he questioned, as we stood next to the lightbox displaying a black and white image of Gary's gut. "The small bowel" I replied in an upward inflection, ever unsure of myself. "Yes, and what's that?" he probed further. "A massive bowel obstruction", I guessed, worried that my obvious answer would not be correct.

Medical school had taught me bones, vessels and muscles, receptors, binding sites and side effects but it also had slowly dissolved my confidence. I once spoke with purpose, but now I answered silently in my head, despite my correct diagnoses.

"Good get, he's gonna need surgery", he declared. "Can I please observe, I don't mind staying if there's room for a student?" I campaigned. "Go get your sized gloves and a gown. You can scrub if you like. Can you hold a camera?" I'd done it twice, which had slowed the team considerably as I mixed up my left and right, under pressure. "Yes! I can hold a camera", I hoped my enthusiasm would make up for my lack of experience. He laughed. "No, you probably can't, but go on!"

I met Gary again in the anaesthetic bay. He acknowledged my presence with a beautiful wide grin. His perfect white teeth now showed a good-looking young man. He held up his hand. "They attacked me", he joked, demonstrating the many small circular Band-Aids which marked the failed attempts to cannulate his veins. "They don't care", he said dismissively. I stopped what I was doing and reached for the small round black stool. Scooting it over to Gary, I didn't respond. It felt like he had more to say. He breathed out heavily then spoke again, out loud but not really to me. It was more of a monolog. He detailed his own, his family's and his community's many accounts of poor treatment. He discussed the barriers of accessing the hospital, both logistically and culturally. He reeled off sensible suggestions for improvements and well thought out recommendations. He used the words responsibility, advocacy, human rights, culturally appropriate care and connection to Country. He concluded by saying that he'd rather die than come back here. He explained the distrust and public opinion of the hospital from the local Aboriginal Health Service, summarising with a self-depreciating dig at himself, explaining that no sane man waits to seek healthcare for three days covered in vomit and faeces. But he did, because his prior experiences of care here were worse than that. I just listened. And when he was done, he said, "ya know, Sis? And the thing was, I actually did.

As an Indigenous medical student born to an Aboriginal mother, amid the 1950s Australian Government's policies and practices of assimilation, which included the removal of babies by forced and coerced adoption, I live the betwixt experience of intergenerational separation and the trauma that accompanies it.

I innately appreciate that the hospital setting holds much fear and an almost complete sense of mistrust for Indigenous patients. As medical students we are fortunate to have access to patients in a unique setting. Not yet responsible for care, yet participants of care-teams, we are able to engage and interact with patients in the peripheral spaces of their treatment. It is in this space, devoid of time critical emergencies, where we can practice and hone our skills, one more history-taking exercise at a time. But it is also the opportunity to listen to our patient's stories and experiences and to better understand the social determinants of their health. These patient interactions should be reciprocal and if presented, we should act on our responsibility to advocate with kindness. Afterall, the past five years of medical studies has taught me to constantly reflect on my learnings. And every day, in every way I find my place in the healthcare setting as an Indigenous person and student, challenging. Because our mainstream healthcare service is not culturally appropriate.

It is rife with racism.

Since my encounter with Gary, I prioritise the patient experience regardless of what limited participation I might have in my capacity as a medical student. I aim to listen first and advocate always. I plan to carry these priorities into my clinical practice as I transition from a student into a healthcare practitioner, remembering that the currency we are exchanging as doctors is human life. The very stuff that we are working with day in, and day out is someone's loved one. As one laparoscopic cholecystectomy blends into another, I vow to know the story behind the surgical drape and care for each patient as a person, not a set of symptoms.

Some mornings I wake up and tell myself, I don't have to do this anymore if I don't want to. Really, I don't.

I get to do this.

And that is an absolute privilege. One that I will always value and demonstrate by way of support and advocacy for every Indigenous patient, and for every patient of every race that I have the honour to care for.

Upon reflection of these sets of events, I have had had the opportunity to form perceptions of or query the responsibilities and perhaps demands that I felt exposed to. Initially in the acute aftermath of witnessing these acts of racism and racial stereotyping I catapulted into action or what one might call "damage control". I researched the Hospital's policies on discrimination, intent on advocating for patient rights through the Hospital's Reconciliation Action Plan, engaging with the local Aboriginal Community Controlled Health Service in our region as well as the Rural Clinical School teaching campus. I felt compelled to champion some type of change to right the wrongs that I had witnessed. I spent long nights

discussing why these sets of events happened and at what point, in my capacity as a medical student and a soon to be Junior Medical Officer could I have intervened better to provide safer care. Care aligned to Gary's cultural beliefs and customs, care that empowered and educated him. Care that provided him with the universal respect that he and every other human should receive as their birthright. Care that promoted access and trus, and care that prevented less critical health outcomes.

Witnessing Gary's lack of all these types of care had ignited in me a guttural drive. This time is difficult for me to reflect on, as well as challenging to describe in words. It was and still is a sheer pulling of my heart so strong that I write this with a lump in my throat and the sting of emotion in my eyes. The immediate weeks following my interactions with Gary exposed me to the realities of the limitations of healthcare for First Nations people in Australia. What followed, I can only describe as a personal call to action.

As an Indigenous medical student, I know the importance of providing culturally appropriate care for our Indigenous community members and patients. As the following weeks continued to pass, my perceptions adapted into a smaller, micro-effort, whereby I settled into the opinion and hope that all medical students and staff training and working at the Albury Wodonga Health service should all hold adequate cultural knowledge and training to be able to offer culturally safe medical care; and that this commitment should be mandated by the employing hospital for all staff and students who will interact with any patients (and therefore any Indigenous patients). This opinion, was formed in the wake of the response to The Voice, No Vote, knowing that our Australian national narrative was one of little support of Indigenous autonomy or self-determination.

As such, I spoke at length with Indigenous Elders residing in the local area who were employed as Cultural Educators at our local Aboriginal Health Service. After much consultation, an opportunity emerged.

I was asked to support a conversation of reconciliation between the Director of Medical Education at the Albury Rural Clinical School and the local Aboriginal community. It was my honour to connect Uncle Sam Jupurrurla Wickman with my Medical Director, who approached the Rural Clinical School with his own ceremonial artwork, which on the back of the artwork, Uncle wrote his offer of reconciliation to the Clinical School and traced his handprint and signed his name. The Medical Director, Doctor Norden returned this gesture of reconciliation and through his own agreement with Uncle, he too put down his hand, made his mark and signed his name in commitment to reconciliation and partnership of Indigenous training and cultural education. Through this artwork, a cultural

partnership was formed whereby both leaders committed to a relationship with the intention to improve the learning opportunities of medical students training at the Albury Rural Clinical School.

It was exciting for me to learn that from this interaction, new cultural emersion projects will be available for commencing students to learn from Indigenous staff as well as engage in further online cultural education modules in the medical curriculum. This new partnership excites me, not just because of the positive impact that it will bring locally to Indigenous patients receiving care through Albury Wodonga Health, but because it demonstrates real progressive change that will improve Indigenous health outcomes. Small progressive change but change non the less. Even more uplifting is the fact that this change is occurring at a time where it feels like the nation has revealed its standpoint on Indigenous affairs, which I personally believe has left many of us feeling demoralised, even further marginalised and unsupported.

Therefore, my personal future practice will be guided by the lessons from these atrocities. I will draw on these acts of racism with further tenacity to advocate for all patients. I will speak up; I will speak up loudly, but with the respect that my Elders have taught me. Because speaking up in partnership promotes change.

I believe that the foundations of our medical training as Australian Medical students should be guided by the articles set out in The Universal Declaration of Human rights adopted by the United Nations in 1948. Which declared that the promotion of universal respect for and observance of human rights was essential, and that all human being are born free and equal in dignity and rights. Such rights are given without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, (Rights, U. N. H. (1961). Universal declaration of human rights., Article 2). The purpose of this declaration was that the power of ideas would change the world. I propose that we put these ideas into action through partnership with other supporting individuals and agencies to form robust collaborations. Because together we can create positive change as demonstrated by the small efforts of a few committed individuals in Albury, New South Wales.

These actions illustrate positive and practical reform. Reform that is necessary in our Australian medical sector if we are to provide appropriate cultural and medical care. As well as reform in our medical education training for Australian medical students. It is my hope that small micro efforts such as the one that I instigated will continue to expand in collective participation until it is common practice that all hospitals and health services provide appropriate cultural health

care, through committed cultural education and training practices for Australian medical students.

I know that we can do this, because we have already started.

The only way that this reform will not work; the only way that this type of improvement will not continue is if we cease our efforts, if we stop and do nothing; And I am proud to say that I will never stop and I am confident to say that I am well supported. Together, through cultural education we can improve the medical health outcomes for our patients, like Gary. All it takes is to listen and to act.

* * *

In conclusion, of this reflective essay, some further details of the partnership between Albury Wodonga Aboriginal Health Service (AWAHS) and The Albury Rural Clinical School (UNSW) have been included for context.

UNSW and ACCHO strengthen relationship

On National Close the Gap Day this year (16 March), the University of NSW's (UNSW) Rural Clinical Campus in Albury conducted a Reconciliation and Relationship event with Albury Wodonga Aboriginal Health Service (AWAHS), recognising the importance of their partnership. AWAHS is a non-profit organisation that was developed to cater for the primary health care needs for Aboriginal and Torres Strait Islander people and their families. UNSW and AWAHS have been partnering to enable student cultural education and build clinical expertise when caring for and treating Aboriginal and Torres Strait Islander patients. This type of training for doctors and health workers is critical to addressing systemic health inequity.

Looking forward, UNSW is looking to integrate more opportunities for students to learn about Aboriginal and Torres Strait Islander culture and health care. With the support of AWAHS, UNSW is expanding its teaching program at the Rural Clinical Campus to include a 2-day cultural education workshop and are also identifying opportunities to increase the frequency of medical student placements with AWAHS.

In the near future, a pilot longitudinal placement program for Year 3 medical students will commence at AWAHS, providing students the opportunity to engage in longer term care. It is anticipated the student experience and learning within this program will encourage more medical students to consider a career as a rural doctor whilst also graduating with a deeper knowledge of Aboriginal and Torres Strait Islander health care.

To view the *UNSW Sydney* article *Reconciliation & Relationship: strengthening UNSW's partnership with Albury Wodonga Aboriginal Health Service* in full: https://www.unsw.edu.au/news/2023/04/reconciliation-relationship-strengthening-unsw-partnership-albury-wodonga-health-service

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Below, I have included the typewriter print on my mother's birth certificate which states the words *unmarried, woman of colour** which details the reason and circumstance pertaining to her adoption in 1952, at The Royal Women's Hospital on Grattan Street, Carlton, Melbourne; where Aboriginal babies were forcibly removed under the 1915 amendments to the *Aborigines Protection Act 1909* which gave the New South Wales (NSW) Aborigines Protection Board the power to remove any Indigenous child at any time and for any reason. The phrasing of one amendment was so broad as to enable any interpretation by the Board's inspectors and led to thousands of Indigenous children being taken from their parents on the basis of race alone. This government-sanctioned practice was widespread across Australia, and created tens of thousands of Aboriginal and Torres Strait Islander members of what are now known as the Stolen Generations. (The Museum of Australia, 2023, cited https://www.nma.gov.au/defining-moments/resources/aborigines-protection-act).

Section 13A, Aborigines Protection Amending Act, No. 2 of 1915:
The Board may assume full control and custody of the child of any aborigine, if after due inquiry it is satisfied that such a course is in the interest of the moral and physical welfare of such child. The Board may thereupon remove such child to such control and care as it thinks best.

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