Pseudonyms have been used in this essay to help maintain confidentiality.

I confirmed her details; her name was Andrea Jones, she was 64 and she was a retired receptionist. Her presentation was simple enough; she had been experiencing intermittent episodes of right upper quadrant pain. These episodes were usually triggered by fatty meals and self-resolved after an hour or so. Her symptoms screamed biliary colic, and I felt confident that I would be able to present this patient’s story to the consultant without any problem.

After establishing my provisional diagnosis, I moved on to ask about her comorbidities. She had the usual cocktail of hypercholesterolaemia, hypertension, type 2 diabetes mellitus and gastro-oesophageal reflux disease, coupled with depression and anxiety. All of these were reported to be well-controlled by lifestyle advice and medication prescribed by her general practitioner. She had no other medical history to report, until I asked about surgeries.

Ms Jones reported a tonsillectomy and adenoidectomy during childhood, and a hysterectomy 20 years ago. Then she paused and her expression became grave, I developed an awful feeling in the pit of my stomach. “I have also had many surgeries on my arms and legs and have had two surgeries on my neck.”

We both knew I knew what the answer was, and I did not know if the question was appropriate, yet I still asked what the cause was. She looked me straight in the eye with a look of fresh terror, nodded her head slightly and whispered a single word.

I did not say anything; I did not know what to say. I allowed for silence – that is the only thing I could remember from the ‘Breaking Bad News’ tutorial we had in first year. Then I realised that I was not the one breaking the news and internally panicked. Fortunately, the silence seemed to be what Ms Jones wanted. She took it as an opportunity to tell me her story.

She had been with him since she was in her twenties; they dated, married, had children. Everything was swell until it was not. He started to hit her; she thought she could cope with it.

Ms Jones paused, and I nodded for her to continue.

The beatings became more severe; she was scared to be at home. She ended up in hospital numerous times. The first time he broke her neck, she was going to leave. She almost did until she thought of how it would tear her family apart.

Her eyes started to swell with tears, I offered her tissues. She dabbed her eyes, and I held her hand.

When it happened the second time, her eldest child insisted that it was time to leave. They did, and it was hard, but they managed. That was a decade or so ago.

The conversation came to a natural halt, Ms Jones looked more comfortable now. I am not sure if this is the right word to describe it, but one could say she looked almost relieved.

“What is it like now?” I asked. She half-smiled and told me that she had remarried. She was
happier now; her new partner was kind and gentle, but she was still scared, always scared. Ms Jones let go off my hand and sat up straighter. “What else would you like to know?”

It felt unnatural to continue with the history-taking as usual, but I knew it had to be done. Ms Jones had no family history of cholelithiasis or any other gallbladder disease but did have a family history of cardiovascular disease and diabetes. There was nothing else remarkable in her history; she was a non-smoker and non-drinker, and had a healthy diet. Other than mild tenderness in the right upper quadrant there was nothing of note on examination either. I thanked Ms Jones for her time and told her that I would go and find the consultant.

“Good, you’re done. Now, when you present I want you to focus on the surgical problem at hand. I’m a surgeon, and I want to know what I can fix”, was the greeting I received when I walked into his consulting room. I know he said it in good faith, and he was wanting me to practise my presentation skills as it is an area in which he knows I need to improve. However, when I summarised the abuse Ms Jones has suffered as “complex social issues”, I felt as if I was ignoring what she had said, as if I was cheating her.

Despite this, the consultant seemed happy with the presentation, and proceeded to consent Ms Jones for an ultrasound and discussed the potential need for a cholecystectomy. She agreed to all he said, said thank you, and left to organize her scan and follow up appointment. The consultant went back to his desk, and as if I had not just been mentally shaken, I went to call for the next patient.

The consult with Ms Jones was the first that I had ever had in which abuse had been openly discussed. It was very confronting for me; I have lived a very sheltered life and my exposure to such issues has been very limited. It made me realise that this career will expose me to a number of social issues that I had previously only heard about on the news.

One thing that I found difficult was coming to terms with was the fact that despite not knowing me, Ms Jones instantly trusted me with such personal information. I am not even qualified, a mere student on her first year of clinical placement. Furthermore, I am less than a third of her age, young enough to be her granddaughter, and yet she still trusted me. The simple label of “medical student” was enough for her for her to feel comfortable to tell her story. We had been told that this would happen on our first day of medical school, but the truth of the statement had not resonated for me until this consult. It made me realise the extent of the power imbalance in the doctor-patient relationship; how we can ask virtually anything and it could still be acceptable, yet the patient knows nothing about us apart from our name and position.

Another thing that I struggled with in this relationship was determining where the line lay in distinguishing appropriate from inappropriate professional behaviour. I did not know if I should have asked Ms Jones the cause of her injuries, and was not sure what the “correct” manner was to react to Ms Jones’ emotions. The whole while I was just following my gut instinct; there was no textbook or flow chart to follow. This made me uncomfortable – I did not want to say or do the wrong thing to make the situation worse.

I also did not know whether it was appropriate or not for me to hold Ms Jones’ hand. Was that considered to be breaching professional boundaries, or could that be considered to be a kind gesture? I hoped that she didn’t come from a culture that deemed it inappropriate, and hoped that the fact that she had been physically abused would not make her uncomfortable when a stranger held her hand. I was relieved when she did not react negatively when I did.

Finally, I felt uncomfortable with presenting back Ms Jones’ abuse as “complex social
issues”. I felt that Ms Jones and I had formed a good relationship during the consult, and then felt that I had betrayed this relationship when I summarised her past into those three words. However, I did recognise the consultant’s point of view and understand the importance of targeting the relevant issue, particularly since this social history was not an “active” problem.

Overall, the student-patient relationship that I had in this consult was unlike any that I had experienced before. Despite my discomfort, I felt that the experience was a valuable one, one that I learned a lot from, and one that I will remember for a long time.

I think that I handled the situation as best as I could with the knowledge and skills that I had at the time. However, I know that this is level is not good enough for me as a doctor. At medical school we learn how to break bad news, however we have never been taught how to deal with situations in which patients break bad news to us. I believe that this is something that needs to be incorporated early on into medical school curriculums. This is particularly relevant for discussions involving domestic violence as it is such a prevalent issue in our society.

I am aware that the Royal Australian College of General Practitioners has recently started a program to educate general practitioners on how to have such conversations, and am of the firm belief that medical students should have similar training too. This could be done in pre-clinical years so that when we are confronted with such situations in our clinical years we know how to approach them. It may even be more beneficial to us to have teaching in this area at this stage rather than breaking bad news as that is not something we will have to do as students.

The teaching could be done with simulated patients in a safe environment. Tutors and simulated patients can provide feedback regarding what we said and how we acted, and what we could do differently if presented with a similar situation in the future. The issue with this learning strategy, however, is that it is artificial and students may struggle to take it seriously. However, this training would be better than the lack of training in this area that we currently have.

We should also be made aware of the support services that are available for patients experiencing abuse. This is so that when we graduate, we will be able to refer patients so they can receive more targeted help. In the situation as a surgeon’s consulting rooms, this knowledge will be vital so that one can focus on the presenting problem but also know that the accompanying social issues are also being managed.

Currently, there is a focus on teaching medical students holistic medicine. I believe that incorporating education about domestic violence and other difficult conversations into the curriculum will help achieve this goal. It will give us confidence as students to deal with such situations, and more importantly will also have better outcomes for the patients as their problems will be addressed.