'This book has single-handedly restored my faith in humanity. A rare and thrilling glimpse into the life of a frontline healthcare worker, full to bursting with spirit, guts, empathy and love.' EMILY BITTO

THE CARE FACTOR

a story of nursing and connection in the time of social distancing

AILSA WILD

This book was written on the lands of the Wurundjeri people, whose sovereignty was never ceded and whose struggle for justice continues daily. We would like to pay our respects to their Elders, past, present and emerging; to the Indigenous healers who have cared for this country and its people since time immemorial; and to all Aboriginal people and Torres Strait Islanders on whose lands we live, work and care.

THE CARE FACTOR

a story of nursing and connection in the time of social distancing

AILSA WILD

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To the carers – whose work, hours and expertise so often goes unseen and unacknowledged.

This book began as immediate memories told to Ailsa by Sim in recorded conversations in the days following the events they depict. Some people in this story have had their identities obscured by changing their gender, diagnosis, occupation or other identifying features. Other people gave consent to be named and appear as themselves. Some are actually two people magically squished into one for the sake of clarity and simplicity. The whole book is told from the perspective of our friendship – which is just one window of millions into the events of the pandemic in Melbourne. Everything in this story happened.

This book touches on stories of trauma, sexual violence, domestic abuse and Covid deaths. If these topics are difficult for you, go gently.

Contents

The Skill We Need Now

'THERE ARE GOING to be so many half-naked nurses on front porches!' Sim laughs. 'How else are we supposed to take off our infected clothes *after* we leave the hospital but *before* we step into our houses?'

Simone is going through the nitty-gritty of how her days look now: the pathway from her front door to her laundry; how she'll keep her girlfriend, Emily, and their housemates safe from infection; how she's going to stay hydrated throughout her shifts.

'They're getting us to wear the masks *all* the time so we don't waste them.' These masks aren't designed to be simply pushed aside and then returned to position. Once they've touched other parts of the face, they're considered contaminated and need to be disposed of. 'At one point I left the room, did my hand hygiene, took my gown off, cleaned my hands again, grabbed my water bottle and undid the lid. It wasn't until I'd almost

pushed it *into* the mask that I remembered I couldn't drink. Not for another two hours.'

I breathe out quietly on the other end of the phone, aware that my friend is at the very beginning of this journey. Thinking of the hard work that lies ahead for her, where a few hours without water will probably be the least of it.

Sim has put up her hand to retrain for ICU in response to the global pandemic. In other parts of the world hospital corridors are full of patients who don't fit in the wards. They're sending the elderly home without treatment, they're talking about turning ice-skating rinks into temporary morgues. My social media feed shows cities applauding their medical staff from a million balconies. There are memes about how the disaster movies got it wrong: turns out we don't need to know how to shoot aliens or barricade our homes from zombies.

The skill we need is how to care for a sick human body. My friend has this skill.

I don't. My skill is to listen.

Sim is the kind of person who really likes talking. She goes into intimate, gory detail about her work. She explores her emotional reactions and checks my thinking about her relationships. She treats each new patient, each colleague, with a deep, humane respect. She texts me her griefs and terrors in the middle of the night. She's constantly analysing her work through a queer feminist lens, and I'm admiring of, and sometimes utterly exhausted by, her drive towards integrity.

I want to write her story.

'Do you trust me?' I ask. 'I'm not going to ask you to read anything now. Not until it's all over. But later? I won't publish anything you're not happy with.'

'Yes, yes!' she says. And then: 'This feels like such a privilege. Like, why would you do this for me? There are people whose work is so much more important than mine.'

It's true, there are people doing bigger-picture organising work, or whose faces might be even closer to the trauma of this thing. But I disagree that their work is *more* important.

Also … 'But I don't have *this* relationship with them,' I say.

Her voice changes. Grows stronger. 'I know,' she says.

CHAPTER 1

Crisis Respondent

IT'S 20 MARCH and I'm in a doom spiral, fear-scrolling and heartbroken. There are twenty-eight new cases of Covid-19 in Victoria. Yesterday 2700 passengers disembarked from the *Ruby Princess* cruise ship into Sydney. My sister just called from London to ask me to keep my three-year-old home from childcare. It's time.

I've been working from home for years, setting up and packing up my laptop from the kitchen table each day. I think of this house as mine alone. Those hours when Jono is at work and Jack's at childcare, the stretching peace of tea and silence and room for my brain to work – they are what keep me sane.

I'm about to give them up.

I'm supposed to be writing a children's book but I can't focus. I'm afraid.

Instead, I call my friend in Sydney whose grandmother is dying in aged care. Limits on visitors keep shrinking. She's from a big Greek family and everything feels wrong about her Yiayia being alone

for a second. There should be cousins and great-grandchildren and love all around her for these final days. My friend manages to get permission for her children to come in for a ten-minute visit to say goodbye. With her own full-time work, the domestic load, and the children in her face, she sounds like she doesn't have time to grieve.

I call my single friend who is just back from an overseas work trip. She's in quarantine at home alone – facing lockdown as soon as her quarantine time ends. She's been sharing articles about skin hunger and loneliness. I bite back my envy of her space, my longing to be alone. I listen to her sadness. And within minutes she has turned the conversation around to ask me how I'm coping.

I call my friend who is helping to care for her bedridden father. He has a slow, debilitating terminal illness. Someone needs to wake with him several times a night because his bladder is shot. My friend is living a few nights a week at her parents' house, trying to share the load, dressing in cobbled-together homemade PPE when she does the shopping.

I call my friend who's living on Centrelink with two kids and training to be a nurse. I check that she's got the tech she needs for remote learning.

I call my friend whose work as a touring theatre performer stopped overnight to find out how she's planning to manage financially.

I call my friend who's a high school teacher. He is

spending the entire school holidays planning how to deliver distance learning.

I feel like they are all superheroes. I feel like I am part of a great network of carers who are holding up the world and I hope my phone calls lighten the burden. I realise that the phrase 'love makes the world go around' isn't actually about the nice feeling I have in my chest sometimes.

It's talking about the hard, endless, soft, sleepless, exhausting labour of caring for our people.

That labour just got a whole lot harder.

I call Simone.

I make my first recorded call to talk about how she's feeling as the lockdowns roll in. Wuhan, Seoul, California, New Zealand … and now us. I've been listening to ICU nurses in New York talking about their days. The danger. The deaths. The lack of PPE. I want to know exactly what's happening in the hospitals here.

I ask her how she came to decide to retrain for ICU.

'I guess I felt: I'm up for this. I've got ICU experience. I'm fit and healthy and I've got good support. So I'm going to give it a go. For me, there wasn't a question. Sure, there's a part of me that would love to just bury my head in the sand but …'

But people need her help. At the first ICU orientation session, the message Sim heard was, 'We need you. Please come and do whatever you can. If you only come in for two hours to relieve tea breaks, at least that's something.'

She is part of a huge cohort of nurses returning to ICU from other places – education, project management, retirement or maternity leave.

Sim will be stepping back a little from her other main role: training health professionals to recognise and respond to signs of family violence in their patients. 'The thing is,' she tells me, 'all the face-to-face training I was doing has ceased. We can't have people in a room together. No-one's got time. It's not the priority right now.'

She's obviously conflicted about this.

'We know from data around bushfires and other crises that we're going to end up with an escalation in family violence incidents. Isolation at home will just make it …' She breaks off. 'It's really hard for a lot of people. Really fucking hard.'

She explains that, on top of increasing incidences, the family violence services have to find ways to operate with social distancing. 'Social workers are having to figure out what they can do online, from their homes. The refuges are asking questions like, can they take people who've been in hospital, or might they be a risk to other people in the refuge?'

I feel the issues expand in front of me. Of people living in crisis accommodation, of children in state care, of prisoners. How are we, as a society, going to keep people safe?

'So I'm hearing all this info about family violence and my emails are full of it and my job is to make

sure hospital staff have an eye open for it. But you can imagine the barrage of information going through hospitals at the moment. People are trying to filter what they need to know from pages of writing. They just don't have time for it. I wrote one email about the increases in family violence we're expecting. I probably went over it twenty million times trying to make it as succinct and easy to read as I could.'

Her frustration levels are high. This is not surprising, when she's sending emails she knows people might not read.

'I don't have the ability to talk to people about all the details. All I can do is flag it and make sure they know where to look for resources.'

She'll keep working at that for now. But she's also getting ready for something very different. She had her first training in ICU yesterday.

'It was, quite hilariously, the most welcoming experience I've ever had there.'

She pauses to explain. 'Background: ICUs can be snobbish places in the sense that you have to meet certain criteria to work there. They're very strict about it. If you haven't worked there for a while, they will only take you back under specific conditions – so you can receive support and training.'

It makes sense to me. This is about life and death. You need to get it right.

'But we just don't have the ability to run ICUs with the number of staff this pandemic will require. Things

are changing fast and we need to think outside the box. Suddenly it feels like ICU is rolling out the red carpet. They're just having to say, "We want you. We want all of you.'"

It's been five years since Sim worked regularly in an ICU and when she did it was at a smaller, more specialised unit. She's never worked in a big trauma ICU like at the Royal Melbourne Hospital. I ask her how she's feeling about it.

'I'm incredibly nervous. You can imagine that there are a lot of machines. And there are a *lot* of things to remember. There's a lot of immediate recall of what to do at each point that really isn't fresh for me.' Her voice rises. 'And there was a woman in my group yesterday who hasn't worked in ICU for eighteen years!'

On the recording of our conversation, you can hear me gasp. 'Eighteen years! The tech must have *really* changed for people like her.'

Sim equivocates. 'Yeah, but interestingly, a lot of the principles haven't. Bodies are still the same. Blood pressures are still controlled in the same way. The tech has changed for sure, but some of it's become more intuitive.' She laughs. 'You know, like how using an iPhone is actually easier than using an old Nokia.'

Sim explains the way ICUs are run. If a patient is on a ventilator, they have a nurse dedicated solely to them, who does not leave the bedside. The machines control how many breaths they take, the volume of air with each breath and the concentration of oxygen they

receive. Medications are delivered by pumps to control blood pressure and heart rate. The nurse is always there, monitoring the machines and adapting settings and dosages in response to changes in the patient's vital signs.

'I stupidly started the day by reading stories from nurses living the nightmare that is ICU in London right now.' Her voice rises with incredulity. 'They only have one ICU nurse to *six* patients.' I can feel the tension rolling down the phone.

Royal Melbourne usually has thirty-two ICU beds and they're looking to open ninety-nine in preparation for the pandemic. 'So, if we are going to ninety-nine beds, then we need to triple the number of staff, and there's just *not that many ICU nurses*. Even with all of us coming back from retirement and out of projects, there's a gap. So they're also training up a cohort of nurses who haven't worked in ICU before; they're calling them Fast Track nurses.'

She says they're not just training. They're also 'untraining'.

'They always talk about *danger to self*. Don't go in if there's a danger to you. But nurses are inherently bad at that. If someone suddenly pulls out a breathing tube or is bleeding everywhere, we tend to go straight in. We should wear gloves, of course, but in that moment, we often just do what we can to save that person's life – then deal with ourselves later.'

They've been training in how to put on Covid PPE. They have to pay attention to exactly how they handle

the mask and breathe strongly to test if they have a seal. The mask is tight-fitting and it takes time to get it on. It takes time to get it right.

'If I look into a room and someone's arresting, I can't rush in and save that person's life. I have to diligently put my mask on and focus on myself first. It's actually going to be really hard.'

But Sim's trainer told them, 'Look, the thing is, how many other people won't make it if we lose one ICU nurse for fourteen days? Even if you're not sick, you'll have to isolate and that has an impact on how many people we could actually save.'

'Yeah, that was just huge,' Sim reflects, and laughs her disbelief.

She explains that the 'pods' of the intensive care unit will be divided to stop the spread of infection. 'Initially, they'll put Covid patients into the isolation rooms, but there are only eight. Once the isolation rooms are full, then they'll go into Pod A and B which can be locked into Pandemic Mode. And then, of course, there will still be all the patients in ICU who don't have Covid – so they'll be in the other pods.

'And then just … we don't know what will happen. But that's the initial plan.'

I'm worried about older nurses coming out of retirement, back onto the wards and being put in the way of infection. I'm worried about the fresh new mothers who had months of maternity leave planned and are suddenly, instead, stepping back into a

risk-filled workplace. I'm afraid of our hospital system being overwhelmed. My sister in London works for the National Health Service. Just days ago, she was telling me about clearing entire mental health hospitals to make way for palliative care wards. Wards for the Covid patients over sixty who they won't be ventilating. Who will quite probably die.

I'm scared for my parents who are far away in New South Wales. Sim's parents are even further, in Western Australia.

But we don't talk about our families.

It's easier to focus on the details of the organisation and planning underway. It feels both compelling and reassuring.

'They're trying to work out an estimate as to when we expect to see patients at the hospital. When we expect to be flooded. And the interesting thing is, they don't think it will peak for us until late April.'

The hospital was planning to roll out a new system of electronic medical records in April but they've slammed the brakes on that. They don't want to be teaching hundreds of staff how to operate a whole different record-keeping system in the middle of a global pandemic. They'll do it in July, when hopefully the peak will be over.

'We're going into a period now of potentially four weeks of not much happening from a hospital perspective. So we have this amazing benefit of time to prepare in a way that Italy didn't. And the UK didn't.

Those countries were flooded with ICU needs before they had time to think what was happening.

'Whereas we don't have any patients with Covid at the moment at Royal Melbourne, so we're in total preparation mode. Teams are being formed. People are being brought on. Recruitment is happening.'

Sim pauses and slows. 'It's weird. It's like preparing for a war, but the war's not here yet.'

CHAPTER 2

Sexual Health Nurse

'HI, I'M SIMONE from the Sexual Health Service,' she said. Then she paused to wait for the interpreter.

While retraining for ICU and doing what she can in her family violence role, Sim is also still working at the Austin Hospital one day a week as a sexual health nurse consultant.

Things are different now because of Covid. Previously, these consults were conducted face to face, but now Sim has to work over the phone. All the nuances of facial expression and body language are no longer available to her. For this session she had the added complication of an interpreter.

'I'm calling because your doctor referred you to our service.' Pause for the interpreter. 'We see people who are experiencing sexual problems after their illness or injury.'

Her patient was an older man who'd had his prostate removed.

'He is worried,' Ronnie, the interpreter, explained, 'because when he climaxes, it doesn't feel the same as it used to. Nothing comes out.'

Ronnie was also older and both men's voices sounded similar over the phone. Ronnie spoke English with a strong accent, so Sim had to focus just to hear when he switched languages.

Sim explained that no, a dry climax is normal for someone who's had a radical prostatectomy. They can orgasm but no longer ejaculate. Some partners of people who've had their prostate removed see this as a plus: one mess they no longer have to deal with.

Sim has been trained to work with interpreters. She keeps her information clear, uses short sentences and lets the interpreter translate before moving on. But each time her patient spoke it was in long rambling paragraphs. Ronnie responded to the patient to clarify things and there was some discussion before he eventually came back to Simone with a brief reply.

Sim knew there was a whole lot more conversation going on between the two men than Ronnie was interpreting but she found it hard to read the situation. Should she ask Ronnie to elaborate? Or trust that she didn't need to hear all the additional things her patient said? In a consulting room she would be able to read body language and get more of a sense of her patient's response. On the phone she had far less to go on.

This patient should have had it explained to him that he would no longer ejaculate. He'd had preoperative

and postoperative appointments with his doctor, and erections had been discussed, 'but not very much'.

Maybe he missed the information – with the interpreter and so much to communicate. Maybe his health professionals didn't tell him.

They were midway through the assessment part of the consultation and Sim had spent about half an hour trying to find out his concerns and how his body was functioning. They began talking about his erections. He explained that he'd been taking Viagra, but his erections weren't as hard as they used to be.

Then there was a click.

The interpreter was gone.

'Ronnie?' Sim asked. 'Ronnie?'

Nothing.

Into the silence her patient said, 'Ah. No. Inter-pre-ter.'

Sim told him, 'Okay, I'll call you back.' And hung up, not knowing whether he understood.

She called the interpreting agency who couldn't get the interpreter on the phone. He was just gone.

They gave her another interpreter, a woman this time.

Sim and her patient had to launch back into a conversation where Sim was asking him to describe the details of his erections.

As her patient continued to talk, she had a wave of gratitude for his tolerance and openness to having this conversation.

Sim asked, 'Would you like me to talk about the options for erections?'

'Yes,' he said.

She said she could talk more about pumps or injections to make his erection harder. 'And I could also talk about using your body in other ways, stepping away from penetration and thinking about what else you could do sexually. Which of those would you like me to talk more about?'

'I would like more information about the last one,' he said.

Sim isn't a trained counsellor. She's a nurse whose job (on these days) is to talk about sexual function. But the role requires a lot of sensitivity and a willingness to ask and talk about things people often find difficult to discuss. She didn't want to assume anything about his knowledge. Perhaps he was already an incredible, diverse lover, adept with his hands and his mouth. But perhaps his only experience was penetrative sex. She began to talk about mutual massages and intimate games.

'Ah yes,' he responded. 'I'm familiar with some of these. I like this idea.'

Sim wanted to get a better understanding of what was worrying him about his lack of ejaculate. Looking at his age, she thought it probably wasn't a fertility issue. But she couldn't be sure.

He explained that, in his culture and in his family, they believe that if you don't ejaculate, it causes cancer. His operation was last year and since then he'd been

terrified the lack of ejaculate meant his cancer was coming back.

Sim talked him through the anatomy of his operation. That the glands that produce the seminal fluid had been removed, and tubes that carry semen had been cut, which means there shouldn't be any fluid when he ejaculated.

As he listened and responded she could hear the relief in his voice. 'Thank you,' he said. 'That's been very helpful. Thank you.'

After Sim tells me the story she says, 'I'm really sad he didn't get that answered earlier. He should have known before his operation last year and he's been sitting on that anxiety for months. It's weird in the middle of a pandemic, where we're trying to manage staffing and this scary new virus and then caring for really unwell people in ICU. In the middle of all that, someone's really worried their cancer's coming back because he can't ejaculate.'

I can hear the smile in her voice as she says, 'In some ways it was really awesome for *me,* to talk with that gentle man about a problem that was so solvable.'

Sometimes Sim and I don't talk about work, we just hang out on the phone together.

'I miss you,' I say.

'I miss you. I was thinking about that secure feeling of holding your hands as I tuck upside-down or when your hands are wrapped around my arms when I lunge into arm-to-arm.'

Sim and I were in each other's orbits for years, in the quick-hello-hug-phase of warm acquaintance. We eventually formed our friendship in our acro-balance class – a class that Sim's girlfriend, Emily, teaches.

We came to acro as adults, so we know what it's like to feel clunky and heavy and ridiculous while trying something new. We know what it's like to fall in a laughing pile on the floor together, or to achieve a thing that an hour ago felt impossible. We've iced each other's injuries and squealed at videos of ourselves succeeding. We're in our forties.

I returned to acro when my baby, Jack, was three months old. Milk leaking through my sports bra, my pelvic floor managing lifts but certainly not star-jumps. Obsessively checking my phone to be sure Jack was safe and that Jono, my partner, was coping without me. They were fine. I was a ball of nerves – and Sim was the person I whispered my anxieties to while we stretched.

Sim used to arrive at acro in astonishing leggings – printed with luminescent jellyfish or shimmering peacock feathers, or a haunted house with bats. People exclaimed over them and she would smile widely, 'I know! Aren't they great!'

But she's not the kind of person to simply enjoy the admiration and envy of the class. Within a fortnight, she had been hunting through online sales, and before our warm-up she tipped a bundle of leggings on the floor to give away. Galaxies, cloud bursts, reefs of

fish – she handed them out. Some days, more than half the class would arrive in leggings Sim had found for them.

But she kept the crowning glory to herself. Her long legs shone in a rich dark gold that reminded me of Tutankhamen. When I came closer, I realised the image on the print was maggots. Hundreds of golden maggots.

Now the acro class has closed its doors. We aren't allowed that close to each other anymore.

Acro is a touchpoint for how Sim and I talk about learning and trust and relationships. Through acro, we've built a reciprocal confidence in each other's strength and ability to communicate. We judge the risk of each new trick together, anticipate, encourage, and then attempt. We entrust our bodies to one another.

I wonder if one reason it's easy for me to do this is because people entrust their bodies to Sim every day. It's her job – to care for their bodies.

Over her next few shifts in the sexual health service, Sim talked with a woman in her twenties who was in rehab after a traumatic spinal cord injury.

'I don't want to just lay there like a doll,' she said to Sim. They workshopped the possibilities for different positions and how she might experience pleasure herself.

Sim talked with a woman in her sixties who had bowel cancer surgery. She was worried about resuming

sex with her scars and how to manage her stoma, and was nervous about pain.

Sim called a man about sexual difficulties related to a chronic health condition but, after forty minutes of conversation, learnt that he'd been caring for a bedridden ex-boyfriend for years without support. She connected him with carer supports and LGBTQIA+ groups and encouraged him to talk to his GP about NDIS. Sim could have just talked him through physical sexual health information, but she didn't. She could see that his sexual health depended on him making changes in his home life and support base.

She called a couple who were feeling lost and guilty about a new lack of regular sexual intimacy now that one of them was moving towards end-of-life care.

'There's no way they would pay to see a sex therapist,' she says about this couple. 'I find that in this sexual health nurse role, I'm often an intermediary. I have the credibility of working at the hospital but I'm not a psychologist or a counsellor. I'm "just a nurse". It means people feel safe with me, I think.'

For some people, it's far easier to see a health professional about their 'body' than it is to seek psychological help around issues that are deeply personal and close to their hearts. The word 'nurse' implies practicality and trusted medical solutions – but some people come to Sim when medical doctors can't fix their problems. She unpacks their feelings and steers them towards mental health services. 'When I got this

job, I didn't realise how much of a gateway I'd be for people,' she says.

She sees people whose beta-blockers or tricyclic antidepressants impact their libido. She sees people whose spinal injuries have impaired the complex nerves that trigger vaginal lubrication. People whose pelvic surgery or radiotherapy might impact sexual function in any number of ways. And this is only the beginning of the list.

Part of this role is also to educate other health professionals in talking about sexual health with their patients.

This is not automatically covered at university.

Often health professionals think someone else is doing that job: 'Oh, I'm sure the doctors are having that conversation' or 'the social workers are onto that' or 'that's the OT's job'.

Sim wants them to know that it's all of their jobs.

She's also clear that it's really important we aren't just having these conversations with the young and able-bodied. Sim asks her colleagues to consider who they think they *don't* need to talk with about sexual function. What assumptions do we make about a woman who is eighty and single? Or a man in a wheelchair without much control of his arms or voice? Why do we think we don't need to talk to them about their sexual health?

And what health issues do we miss when we don't talk about it?

The medical profession, historically, has dehumanised people by desexualising them, or disregarding sexual function as a health issue. The chronically ill, the disabled and the elderly are often mistaken for no longer being sexual. This can lead to significant omissions in health care.

Sometimes we forget that we've already had a pandemic in our lifetime. Because HIV was first considered in the West to be a 'gay disease', it was allowed to spread devastatingly far before, medically and politically, people stepped up to fight it. People didn't want to ask the physiological questions of exactly how it was spreading. Most of the medical profession weren't talking with their patients in an open, unbiased, *human* way about sex. And that killed us.

Healthcare professionals having the capacity and skills to talk about sexual function is good for public health. It's good for everyone.

But sometimes nurses have a reason not to talk with their patients about sex.

One day in 2018, when Sim was training a group of health professionals in how to talk about sexual function with their patients, a younger nurse put up her hand.

'What if a patient wants to talk about sex – but in a way that makes you feel really uncomfortable?' she asked. The nurse looked vulnerable and nervous.

It raised a red flag for Sim. It sounded … familiar.

She asked the group if anyone else had had an experience of patients talking or behaving in a sexual

way that made them feel uncomfortable. Out of a group of thirty, mostly women, almost everyone raised their hand.

Sim talked to me about it after our acro class that week.

In acro, Sim flies over my head or twists in a series of arcing bends over my upraised feet. I can lift her high in my hands and take the weight of her as she stands soft-footed on my shoulders.

I trust that she trusts me.

I noticed our reciprocal trust at a whole new level the day she began to tell me the stories of being sexually harassed by her patients.

As she spoke about the man who growled sexual obscenities at her again and again from his bed, I realised that what she was saying was both horrible and completely unsurprising. She was a young grad nurse and had gone back and back to his bedside to care for him that night. She went home feeling awful, but never thought of it as sexual harassment. Every time she goes past that ward she still, years later, remembers that man and feels sick in the pit of her stomach.

Sim's younger cousin, also a nurse, had been sexually assaulted by a patient, and then had her complaint dismissed by her superiors. Sim told me about one of her students whose patient had grabbed her and pushed his body up against her in the shower. There were others. In each story a nurse carried on centring her patient's care, making sure he was safe and that

her job was done – and often kept working until the end of their shift before making a complaint or report. In each story, someone dismissed the validity of the nurse's feelings.

Sim, who couldn't fight for herself when she was a grad nurse, had a fire in her belly and an overwhelming protective instinct to fight for her students and junior colleagues. She listened, helped them file complaints and emailed their superiors herself. Now that she had her ear open, more nurses kept telling her their stories.

I suggested that we pitch a co-written piece for an anthology of Australian #MeToo stories. Sim wrote and I edited. Then she talked, I wrote and she edited. One Saturday night we ate ice-creams on the footpath on Smith Street while she looked over the final pages.

'I think it's done,' she said. 'Is it done?'

'It's done.'

I sent it off. It was accepted.

As part of the book's publicity, an extract of our piece was published online and there was a flurry of responses. At first they were from other nurses contacting Sim to tell their stories.

It shattered my confidence in myself as a worker.

I think we all have similar stories which we've fobbed off.

I've found it awful that we just continue on and ignore it. It's a very violating and helpless and disappointing feeling.

I didn't report them.

Raise this issue in any nursing tea-room and the stories will erupt. Mentioned this article at lunch yesterday and there was not a nurse in the room (we were all female) without multiple stories.

The Director of Nursing at the Royal Melbourne Hospital sent the article to all her unit managers, asking them to read it. The CEO of the Australian College of Nursing arranged a conference call with us from Canberra. She'd read our piece that morning and she wanted to get a team together to write a position statement *now*. Would Simone co-chair the committee?

The Director of Nursing at the Austin invited Sim to speak at what they call a Grand Round – a monthly formal educational meeting for nurses. Sim stood up in front of a packed auditorium of health professionals to talk about sexual harassment of nurses by patients.

She sent me the video.

On the screen Sim stands tall and her straight grey fringe shimmers silver in the lights. She's quick and I barely notice she's moving, but one moment she's at the far left of the stage, throwing her smile to the back of the room, and the next she's at the front, talking with someone who's answered a question, bringing everyone in.

She asks a hundred people: 'How do you think you would respond to that behaviour? Not how should you. How *would* you?' They answer her with their vulnerabilities, their hopes and their mistakes. Somehow, she's having an intimate conversation about

how much she wanted to protect her cousin with a huge auditorium of people.

'Who here has googled nurse costumes?' she asks.

The groan that rises from that roomful of nurses tells me everything.

Sim carefully talks everyone through the legal definition of sexual harassment. Then she puts up an interactive survey slide.

'Have you ever experienced or observed sexual harassment behaviours from patients or consumers in your workplace?'

As people log on to their phones to answer, the results go up on the slide. The 'yes' column shoots up and hovers at around 86 per cent.

Since Sim started looking, it has become very clear that nurses are being sexually harassed in all our hospitals.

Is it because nurses are so often women? (In Australia, 90 per cent of the nursing workforce are women.) Is it because nurses perform tasks that are both intimate and menial? Is it because they are seen as being there to serve? Is it because, in a hospital bed, people might feel disempowered, and this is a way for them to assert their power?

Sim has trawled the research on this, and there is no clear answer. She pulls up a graphic showing the pyramid of gendered violence. At the top are the murdered women. Further below sit sexual harassment and verbal abuse.

'So we might feel, when we are being harassed, that we're tough enough to handle it,' Sim says. 'But when we speak up for ourselves, we are actually standing up against the murder of women.'

After the Grand Round, the Director of Nursing at the Austin asked Sim to be part of a new sexual safety working group. She wanted to know who was reporting sexual harassment and how, who was staying silent and why? What were the gaps in their workplace policies and procedures that were letting nurses down?

As Sim began to do her sexual health nursing consults from home to reduce the risk of Covid infection, she was also preparing for the sexual safety working group. In the times between sexual health consults, she pulled together snapshots of articles she'd found about harassment of nurses by patients and did a gap analysis of the hospital reporting procedures.

In one consult, she called a man who, until recently, did physical work with his body. In April he had a forklift accident resulting in multiple pelvic fractures and other long-term injuries to the lower half of his body. As the first and then second waves of Covid hit, he'd been living in a regional rehab unit. All the other patients on the rehab ward with him were elderly or had dementia.

He hadn't seen friends or family for four weeks because that's how long it had been since hospitals stopped visitors entirely. 'No-one else here even knows what coronavirus is,' he said to Sim when they spoke.

Restrictions were ramping up and he was facing at least another six weeks with no visitors.

He told Sim that he was married. 'But she's only forty-nine. She's in her prime,' he said. They'd been together for twenty-five years and used to have sex two or three times a week and he said it was really important to both of them. It was the thing that kept them connected.

'She didn't choose this,' he said to Sim. 'Maybe I need to tell her to go find another sexual partner because clearly I'm no use to her in that way anymore.'

Sim responded carefully. 'Well, that's definitely one option, but what do you think she'd say if you said that to her?'

'Oh, she'd hit me,' he replied, with a little laugh.

He wanted to talk about options for erections, so Sim talked him through different medications and pumps and vibration; the benefits and issues of each. Then they talked about exploring other sexual options. He said that using fingers and hands is something that he has done. He knows his partner values this, not just penetrative intercourse.

But it was going to be a long time before they saw each other again. Sim told generalised stories of people who, as a result of prostate cancer, spinal cord injury or other illnesses, have lost the ability to have an erection, but not lost the ability to have a satisfying sexual relationship.

Sim talked about the idea of 'keeping the pilot light burning'. It's something she heard at a conference about sexuality and cancer.

Sometimes, in the thick of an illness, sexuality is turned all the way down. You're not flaring up the heater at the moment, but it's good to think about what you can do to keep that pilot light burning. What are the connections you can have that are still okay right now, physical or emotional – those small intimacies?

He was doubtful. 'I'm not going to see her for six weeks. We've only got, you know, a phone and screen. There's nothing we can do.'

'Well, maybe we can workshop some options.'

'Are you talking about *sexting*?' he said, sounding startled.

'Well, that's one option,' Sim said lightly and they both laughed. They wouldn't be the only couple connecting this way for the first time since Covid hit. 'Or you might just send her a memory of something. It doesn't have to be about sex, it could be about anything, but an intimate moment that you shared together and what you remember about it, how you remember it feeling.'

As they talked more, he started thinking about a gift he could buy her and send with his love.

He and his wife hadn't really had a conversation about sex since his accident. He was deep in his grief about it, but he thought she had just been really worried about him getting home and logistics and how they were going to manage. Now, suddenly, he had an opportunity to talk.

'But,' he said eventually, 'it's just that, as a man, you have this feeling that you just have to conquer. And if you're not a breadwinner and you can't bring money home to the family, and you don't have that sexual prowess in bed, then what are you?'

Sim was slightly taken aback, but she also liked that he was being honest and self-aware. And neither of them was in a rush. She didn't have another appointment. He was in a rehab unit with strangers and no visitors.

They talked and talked. In the end he answered questions like, what does it mean to be a man? And where do we get these messages about why men have to conquer? What is masculinity? Why are there words like 'virile' and 'potent'?

After she tells me about the consult, Sim sighs. 'At the end of it, I felt like we'd done something good together. It's such a hard story and such a sad story, but I really noticed the scope of my knowledge and the way we built a connection. It was a worthwhile thing in amongst this Covid pandemic. If I'd decided that talking about sexual function wasn't important right now, I would have missed that moment.'

CHAPTER 3

Cancer Nurse

'SIM, HAVE YOU got a moment? Can you just go and take that patient's cannula out? She's been in radiation pre-planning all day and she seems a bit flat.'

'Okay.'

Sim found herself in front of Asha, a young woman in her late twenties who had just been diagnosed with metastatic melanoma.

'How are you doing?' Sim asked, getting organised to remove the cannula.

Asha didn't look up, didn't make eye contact. Her voice was heavy and dull. 'I just need to get out of here,' she said.

It was the start of April, early in the first pandemic lockdowns in Australia. Sim was doing one of her occasional casual shifts in radiotherapy – an outpatient unit at Peter MacCallum Cancer Institute.

Peter Mac, as it's known by almost anyone who's heard of it, is the cancer hospital that sits across Grattan Street from the Royal Melbourne Hospital. There's a

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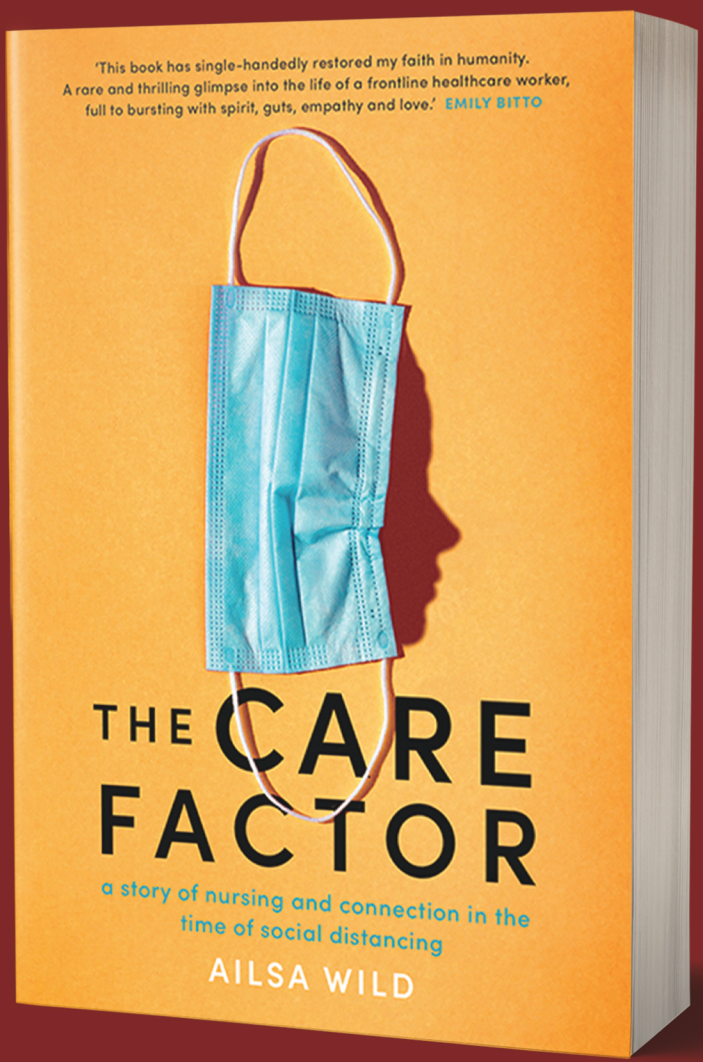

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