NARRATIVE CASE STUDY

Diagnoses are Stereotypes: Go Where They Are

Dustin L Larson

I found Steve resting up against a window ledge outside a soup kitchen. He was on the periphery of a group of about 30 adults who were milling around outside the kitchen waiting for breakfast. Most of the people were engaged in conversation; a few were involved in playful antics reminiscent of a grade school playground. In retrospect, I think I approached him because he was where I would have been: on the outside, alone, not in the middle of the crowd. I introduced myself as a medical student writing a paper about homelessness and health care and asked if he would be willing to answer a few questions. He didn't say a word and started shuffling down the street, face downcast, hidden deep in the hood of his sweatshirt. I tentatively followed.

A coarse, graying beard and a thin, dirty nose were the only features of his face I could discern as he turned away. I couldn't think of anything remotely intelligent to engage him so I asked if he was cold. He stopped, turned, and looked directly at my eyes, then dubiously replied, "I am sweating out here." His clothes were meager and threadbare and he did not appear to have excess corporeal insulation—wholly inadequate for the temperature and wind chill that morning, in the low 20s Fahrenheit.

I told him that I had a spare coat and asked if he would like it. He shrugged his shoulders and didn't say a word as I handed it to him. He searched out the label, looked at the brand name and size, then indicated that he would keep it. Instead of putting the coat on, he folded it neatly and placed it in a basket lashed to his shopping cart, saying that it had been more than a month since he last took a shower and that he wanted to wait to wear the coat until he could get himself cleaned up.

As we made slow progress through the food line, he described himself as a good student who enjoyed school, particularly art classes, and did well academically. Other than fishing, he said that his sports endeavors and hobbies were few. Following high school and in the footsteps of his older brother, he enlisted in the Navy during the Vietnam era. He escaped being sent overseas and his seventeen-month military service ended where it began in California.

Steve returned to Portland and worked skilled-labor odd jobs in manufacturing, sheet metal, electrical, HVAC, and news print industries. At some point during those years he dated and lived with a girl for about six years. He said that things went bad between them and it was very difficult for him. They did not have children and he never married.

The dining room was warm, but raucous with many discordant conversations, wafts of pungent odors, and the noise of a busy kitchen. Steve spoke quietly and succinctly. He made no attempt to compete with the clamor in the room and our conversation became a real test of my hearing acuity and, more importantly, my ability to simply listen. Above the cashier's station was a white board sign with a handwritten menu and prices. The most expensive plate was $1.25. I realized few in this dining room could easily pay $1.25 for a meal. I was immediately troubled and ashamed by the fact that I had spent an entire morning disgruntled about paying a $2.75 parking fee.

Initially, Steve declined my offer to buy breakfast. He had meal tickets that could be redeemed for a plate of food and cup of coffee at the kitchen. He did not say how he earned or received the coupons, but he said that assistance in the currency of dollars and cents was of more value to him because money could buy beer and other necessities the meal tickets couldn't. At the register, he allowed me to buy his breakfast and thanked me.

I stood next to him at a bar while he ate his breakfast. He commented that the scrambled eggs were green, but he could tell by the smell that they were real eggs. He salted the eggs and said the taste was just fine. I asked him a few more questions and his responses remained minimal at best. In a vain attempt to establish some credibility and earn his confidence, I showed him the pages from the Principles of Clinical Medicine syllabus that described my assignment. He

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nodded and continued to eat. I felt I had exhausted all my strategies, so I decided to close my mouth and listen. He quietly finished his breakfast and offered a little more of his story.

He explained that in 1986, he had fallen from an apartment building and shattered both feet and broke both ankles and legs. I asked if the circumstances of the fall were work related. He didn't answer. He said that his experience with poverty and homelessness began in the aftermath of that accident. His recovery from those injuries was slow and incomplete and prevented him from returning to work full time.

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He thanked me again for breakfast, cleaned up his place setting, and headed for the door. In the comfortable warmth of the kitchen, sensation had finally returned to my face and hands and I despaired continuing our conversation outside. On my way out the door, I walked past a long line of people still waiting for breakfast and realized that Steve was unselfishly giving up his seat for them, many of whom he said he recognized, but none that he considered his friends. He told me that he is not involved with much of anything that resembles a community. He said that even though he still has family in the area, he has little contact with them. He said, "I am a loner. I take care of myself. I don't really have any other friends."

When I caught up with Steve outside, he was making some adjustments to things in his shopping cart. He said that all of his personal belongings were in the cart. There is no free place to safely store his things. He can't leave his cart and doesn't trust anyone to watch it for him because he has been robbed so many times. He had a bedroll that was neatly wrapped in a garbage bag and a small, plastic shoebox-sized bin that looked like it contained a random assortment of tools, odds and ends, and personal effects. There was a cardboard box on the bottom of the cart with a few pieces of clothing in it; he had a plastic container and several large sturdy shopping bags securely tied to the sides of the cart in which he stored bottles and cans for recycling. Steve said this is his only consistent source of income. In recent years, competition for recyclables has increased to a point that he walks about five miles per day to earn a few dollars. He does not receive public assistance, worker's compensation, or veteran's benefits. He indicated that he knows about those programs, but he seemed uninterested in accessing them.

Steve opened an old dented and rusty metal tin and pulled out a cigarette butt, lit it with a match, took a couple puffs, then set out on his "route." I didn't ask if I could join him, but he seemed unperturbed by my presence. His gait was stiff and appeared painful. He frequently stopped to scratch the back of his legs and his scalp. He told me that he had scabies—the reason he won't stay in missions: "people in the missions have bugs and the quarters are close so the bugs get around." He sleeps on the street most of the time. He said he put off getting treated for the scabies too long and the infestation was really bothering him. His shopping cart is not allowed on public transit, thus he can only get treatment at clinics or hospitals he can walk to. Three days earlier, he made it to a hospital and received a large tube of permethrin with little result so far.

When I asked him about access to health care resources he was familiar with names of free and low-cost clinics, but didn't indicate that he uses them. He sounded like he had been pretty healthy and free from significant medical or surgical history. His family history was interesting only because of a stroke on the maternal side. He had never been diagnosed with health problems such as high blood pressure or diabetes. His last visit to a physician was about one year earlier at the Veterans Administration (VA) when he tried to get set up with primary care. He said that inability to safely store his belongings and transportation were the only factors that prevented him from establishing that relationship and follow-up through the VA health system.

Other than his current skin infestation, his only specific health complaint was that his feet often felt like they were burning and his legs hurt while he was walking. He said the most effective and available treatments for his foot and leg pain were his attitude and alcohol. He described the pain as "real pain" that medications like vicodin provide some relief from, but he attributed his ability to cope without narcotics to self-determination and will. He was unequivocal about his alcohol consumption and said that it also helped with the pain. He said he began drinking and smoking as a kid and has ever since. Whether by personal choice or otherwise committed, he described several stints at a detox facility and said they don't give a person enough time to dry out. He said he gets picked up by the police two to four times per year for violation of open container laws. His sentences usually involve eight-hour service-oriented activities in the community, which he enjoys.

He stopped frequently to pick up the used ends of cigarettes on the ground and in ashtrays, especially abundant outside nightclubs and construction sites. It broke my heart to watch him park his loaded-down

shopping cart on the sidewalk and stoop down to pick up that precious treasure of his when it was nothing more than garbage thoughtlessly tossed away by others. My instincts were telling me to encourage him to quit, but I found myself picking up "good ones" for him. After we collected a good number he stopped for a rest and to roll a cigarette. His numb hands painstakingly broke traces of tobacco leaves out of the expired stubs and carefully lined it up on a delicate white piece of smoking paper. Minutes into his laborious effort a vicious gust of wind tore the paper from his cold hands and left him unrequited. He cursed quietly, stood up, and continued on his way. He asked why I wasn't wearing a hat and started to offer me one of his. It was the second time that day I was struck with his care, concern, and generosity toward others in spite of his situation and meager means.

As we slowly made our way around town he told me that he hasn't had any bad experiences with physicians or the health care system. He said that physicians have treated him professionally and that he has had no negative experiences associated with stereotyping or prejudice in health care. He did describe occasional instances of less than humane treatment in restaurants and businesses that he attributed to the condition of his clothes and appearance. There is a facility downtown where he washes his clothes every six weeks and it seems his access to a shower is with similar frequency. He lives in one set of clothes unless he is fortunate enough to pick up something new through a shelter or mission.

I asked him if he could recall a fond memory from his childhood or any other time in his life. He almost seemed confused by the question so I asked if he had any pleasant recollection of cherished moments with family, friends, or travels and hobbies; he never answered the question. A few minutes later, I was helping him dive a dumpster behind a bar for beer bottles to recycle and I realized that concepts like joy and happiness might seem foreign or be purposefully stifled by someone in Steve's situation. Without a smile, but with an unmistakable gleam in his blue eyes he said, "We've hit a load here, I'm gonna need a box." He explained the dangers of sifting through garbage to me and complained that the noise from the glass bottles might bother people and bring untoward consequences. He abruptly stopped picking out bottles even though there were others left within easy reach saying, "I'm not greedy, just thirsty."

Our destination was a service station that would give him credit for his recyclable bottles and that stocked his preference for beer. He remarked about the education I was getting by following along with him observing how the other side lives. I agreed that I was learning a lot from him and enjoying the experience as well. Progress up the hill was still slow but there was pep in his stride that I hadn't observed to that point. At a steep side-sloping sidewalk I reached out to steady his faltering shopping cart and he warned me to be careful because the cart was heavy and unpredictable. He said he could handle it and then skillfully maneuvered the cart up to the front door of the station. He carefully sorted out the bottles he knew they would accept and with unassuming confidence strode in the doors to make his transaction.

Reflection

As a student at Oregon Health and Science University, I have had the opportunity to take the Principles of Clinical Medicine (PCM) course, which seeks to provide medical students a patient-centered care context early in their training. This course is a two-year longitudinal course consisting of two components: a classroom experience and a weekly preceptorship in which students spend four hours per week with a community physician.

In my efforts to fulfill the requirements of the PCM course, I found myself considering people on the basis of casual observation of their living situations, physical characteristics, and behaviors—judging using stereotypes. I realize diagnoses are stereotypes.

The first step in the physician-patient interaction is to recognize general patterns in the presenting clinical picture and diagnostic workup. The need to ask difficult questions of patients is a reality with potentially severe consequences. What if I refrain from asking a seemingly innocuous question because I am overly conscious of the possibility of being misunderstood? The information gained from inquiring about sensitive issues or high-risk behaviors is invaluable and applies in almost any clinical setting or patient encounter because it has so many implications for the health and treatment of the patient. If the patient does not volunteer information about risky behaviors or lifestyle, the physician must be prepared to address those topics either as a matter of routine or on the basis of observation of the patient's clinical presentation. Misapplied, stereotyping and discrimination will bring harm to the patient and to the physician but I believe the physician's effectiveness will

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be marginalized without the skills of keen observation and the ability to extrapolate from observation.

The PCM curriculum describes a culturally competent physician as one who recognizes cultural beliefs and practices and uses that knowledge to promote the health of their patients.[1] A variety of influences and experiences as a medical student have increased my level of self-awareness with regard to my own worldview and attitudes and enriched my recognition of different cultural worldviews and practices.

Estimates indicate that as many as 842,000 people experience homelessness on a given day nationally or 3.5 million annually in 2007.[2] The annual public cost of the chronically homeless, who comprise a relatively small proportion of the homeless population at about 150,000 is estimated at $10.95 billion.[3]

Susan Montauk, MD, of the University of Cincinnati College of Medicine, describes the following ten guidelines to consider in clinical decision making when caring for homeless patients: overcoming barriers to care, building trust, diet, access, nomadic lifestyle, medications, patient education, children and adolescents, ancillary care, and physician education.[4] The guidelines are straightforward, patient centered, and immediately practicable by any physician.

My appreciation for the influence of the determinants of culture on how patients experience health care is developing. I am a work in progress and practical recommendations and tools like Dr Montauk's contribute significantly to that process. I propose to become a physician with the medical knowledge and technical ability to treat the body. I desire to be perceptive of the unmet emotional or social needs of individuals, perhaps like Steve, for whom I will be privileged to care. I will respond to them with a compassionate heart and I look forward to learning how to approach them with confidence, knowledge, and whatever resources are available to help meet their needs. ❖

References

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Putting The Parts Back Together Again

[The physician] will use scientific methods, he will for a time dismember his patient—isolate, for instance, his kidneys or his heart and observe their action under very specialized conditions—but in the end he has to put these parts together again in his "diagnosis" … his total conception of the relationships between the patient as a person, the disease as a part of the patient, and the patient as a part of the world in which he lives.

— Thomas Addis, MD, 1881-1949, physician and pioneer in the field of nephrology