

Ethnographic Studies in the Principles of Clinical Medicine

By William L Toffler, MD

In 1992, Oregon Health and Sciences University (OHSU) introduced the Principles of Clinical Medicine (PCM) course with the intent of providing medical students early in their training with a patient-centered care context. Students are enrolled in this two-year longitudinal course at the same time they are learning basic sciences. PCM consists of two components: a weekly preceptorship in which students spend four hours each week with a community physician and four hours in classes focusing on the knowledge, skills, and attitudes involved in providing patient-centered care.

One of the goals of this curriculum is to help students develop cultural sensitivity. This is not an

easy task. To do this we must walk a fine line between teaching salient characteristics of various cultures, which may be regarded as “stereotyping,” and giving vague advice about the importance of treating all patients with equal respect and trying to understand their worldviews.

Another goal is to develop students’ ability to reflect thoughtfully on key issues affecting their future practice of medicine. Students engage in group discussions with their peers and physician group leaders; they also are required to write a quarterly essay to encourage self-reflective thinking and writing.

We have also developed the assignment of an “ethnographic interview.” Students are given the

opportunity to interview a patient from an ethnic or cultural background other than their own. They are then asked to relate the patient’s situation and to reflect upon the experience within the context of what was learned during the PCM quarters, including a discussion of US health care policy and economics. This assignment moves the students out of their comfort zone and enables them to learn things about patients and cultures that they never would otherwise. We consider it to be the best opportunity we offer to promote the practice of culturally sensitive medicine. Our faculty continue to be amazed not only that students learn so much, but that they often write so eloquently about these experiences.

In Search of Home: From Home to Homeless to Housing

By Lianne Lin

The Ethnographic Interview The Presenting Situation

Kathy is a 58-year-old Caucasian woman living in a 55-bed transitional facility for women, most of whom have escaped from domestic violence household or have crossed paths with the judicial system. I met with Kathy through the volunteer coordinator of a program to “help serve people’s basic needs as they transition from homelessness to housing.”

With a group of students I volunteered to make dinner at a transitional facility for men. We had a chance to talk with a few of the residents there. They were very open and shared their lives with us. Hidden in their stories are the secrets of how they became homeless. For many of

them only minimal health care need is met. Since I haven’t had much experience with this subset of our population, I thought it would be a great learning opportunity to chat with one of them more in depth. The volunteer coordinator gave me a choice between a men’s facility and a women’s. I chose the women’s.

The Informant

Kathy was a friendly and pleasant woman. She clearly indicated that she would only volunteer her own information and no details of her family would be shared. She was born in Portland, OR, and her family moved to Albany, OR, when she was eight years old. She lived in Alaska and in California; returning to Portland 28 years ago.



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Divorced, she raised two children by herself. Her son, age 25, is in the military. Her daughter, age 22, is studying psychology in college. Kathy also has an older sister who lives in Lincoln City, OR.

Kathy seemed attentive and willing to share her story with me. She mentioned that she has a hard time concentrating if too many questions are asked at once. Nevertheless, she answered the questions appropriately and rarely seemed to have problems focusing.

Household Composition

Kathy lives in a 55-bed facility for women transitioning from homelessness to housing. It is organized into three levels. Six women share a room (a “pod”) in level 1. In addition, there are a few “correctional pods” for those who are going in or out of the justice system. Everyone enters the facility at level 1, and must complete a set of requirements before moving to level 2. Level 1 residents may not stay out overnight. Level 2 consists of two-person rooms. They share a small space and may stay away overnight for two nights each month. There are 40 residents in Levels 1 and 2. Level 3 is apartment-like. The residents in level 3 have much more freedom and may stay out overnight for up to five days per week. Fifteen people stay in this level. The maximum length of stay is 11 months.

According to Kathy, the facility is strictly regulated with a lot of rules. Everyone must be ready for the day by 7:30 am, and lights are out at 10:30 every night. This is not a problem for Kathy who sleeps only four to five hours a night. Each resident supports the house with required chores. A big-screened TV is shared among the residents: each resident may sign up for a one-hour block per week but are free to join the others in television viewing. No visitors are allowed. When planning an overnight stay away—an option available only to Level 2 or 3 residents—residents must arrange to be picked up three blocks from the house. All incoming calls are taken by a message system, and each resident is allowed one personal phone call per month.

Kathy moved in two and a half months before our interview and was recently promoted to Level 2. She enjoys living in the Level 2 room and gets along well with her roommate. They keep their room very clean.

Material Possessions, Transportation, and Family Support

Although their living space is small, residents in Levels 2 and 3 may have a small TV or any other furniture that fits. When Kathy first moved into the facility, she had only two backpacks and two paper bags of clothes

and belongings. She now has a small black-and-white TV and a small table her daughter made for her. As for food, all residents receive monthly food stamps and food baskets from a central food bank. Most residents use public transportation.

Kathy saw her son when he was back from Afghanistan and she is close to her daughter whom she sees about every two months. She hopes to see her daughter more when she finds her own place. The strict visitation and overnight rules limit their ability to meet. The immediate support system she has includes staff and residents. Each resident is assigned a case manager with whom she meets once a week to discuss immediate and long-term goals: employment and housing. Kathy’s goals also include mental and physical health. She is taking classes about renting and looking for jobs. Kathy is disabled from previous health problems and can only work 20 hours per week. Her disability and age make finding a job more difficult.

Housing Costs

Level 1 and 2 are free; employed Level 3 residents pay one third of their income for rent. Unemployed Level 3 residents pay no rent. Kathy is on the waiting list for a subsidized apartment complex funded by the Housing Authority of Portland; the cost structure is the same as for Level 3 residents in the housing facility. Kathy looks forward to regaining her independence. She is also trying to access Social Security benefits to help with housing and medication needs.

Family Work History and Income

Kathy has never had health insurance, but sees a physician regularly because of health issues. In the past two years, because of increased stress Kathy’s physical symptoms have been aggravated.

Kathy’s last job was at the airport. She provided no specific details, other than lack of benefits. She was fired because of a 13-day absence due to a physical illness. She appealed and will receive unemployment benefits in March 2007. This will certainly be spent on medications.

Health Problems and Medications

Kathy has a list of medical and mental issues. She was diagnosed as partially bipolar, with major depression and anxiety disorders. Her medications for mental health included Abilify 10 mg qd (\$175/month), Cymbalta 60 mg qd, and Trazodone 100 mg qPM.

Her general physical health issues are: congestive heart failure because of valve abnormality, angina, hypertension, asthma, emphysema, right kidney dysfunction (with

35% functional capacity), and gastroesophageal reflux disease. Her medications include Advair inhaler (\$300/month), albuterol, diltiazem 180 mg qd, hydrochlorothiazide 25 mg qd, spironolactone 100 mg qd, diphenhydramine 25 mg, protonix (\$102/month), and Zantac.

About a year ago, Kathy, involved in a 20-year relationship with a man who had emotionally and mentally abused her, first attempted suicide, which led to a long hospital stay. When social workers were unable to find her a shelter, she returned to the same environment. During the next four months, things got worse and she attempted suicide a second time. She was hospitalized for two weeks. She was then placed in the women's transitional housing facility.

Kathy's lifestyle has changed dramatically. She must ration food stamps and the food basket and thus eats more vegetables and less meat. Because she uses public transportation, she has increased her exercise level by walking to and from the bus stops. She has lost 53 pounds since last July. Her weight loss has been a great help to her physical and mental health.

Kathy has now been seeing the same physician for four months and has developed a relationship. She receives financial aid for her mental health medications. However, these resources were not enough to cover everything on her medication list. She has considered stopping Advair and Protonix.

Folk Medical Beliefs and Practices

Kathy has never tried complementary or alternative medicine, cost being a major concern. Because of a recent diagnosis of internal shingles and impaired renal function, Kathy now relies on morphine-related drugs for pain. She doesn't want to become dependent and her primary care physician suggested that she consider acupuncture.

Health Hazards In and Around the Home

I did not ask to visit Kathy's room but she described it and the general house area as being free from hazardous contents. Strict visitor rules allow her to feel safe. She walks around the block after dinner but she doesn't walk far after dark.

Risk Factors for Inadequate Health Care

Kathy has never had employer-provided insurance benefits and she has never purchased individual health insurance. Therefore some underlying health issues have gone unnoticed. With her first suicide attempt

she discovered her failing kidney and heart were the cause of many of her symptoms.

Kathy has few resources and therefore must constantly make decision regarding medications. When her medication financial aid ends next year, those decisions will become even more difficult.

My Personal Reflection on this Interview

A number of issues led to Kathy's becoming "homeless": her abusive relationship, mental illness, lack of employer-provided health insurance, medication expense, and her inability to work more than a 20-hour week because of disability and illness.

Although different trigger events bring the homeless to the street, they all share the same need for food and shelter. Health care and medications are of little concern until a catastrophic event occurs. After all, what was the point of staying "healthy" when starvation and hypothermia are real possibilities?

Upon moving into the women's facility, Kathy came close to mental break down. After completely severing the connection with the life she knew for the past 20 years and after having two near-death experiences, a 55-person house was too much for her. Kathy thought that she and her roommate excessively cleaned their room because this was the only place in the world that belonged to them. "The only thing you have control over is your own room. The world is changing, life is moving along, surroundings are ever different, and you need to stay strong to maintain sanity." Eventually, what helped her through this transition period were rules and routines. They added certainty to Kathy's life.

Before Kathy left her "home," she could not afford individual health insurance; thus, she did not have routine physical checkups. Some important underlying health problems, such as valve abnormality and renal function impairment, went unnoticed. When evaluating the access and quality of medical care for Kathy, she got the minimum to stay relatively stable.

During her suicide attempts, Kathy's needs exceeded her resources, creating debt she was unable to repay. Tracking these numbers added to her depression. She is now working with payment assistant programs at various hospitals that previously cared of her.

Kathy is one of the lucky ones. Unfortunately, thousands of homeless people are still on the waiting list for the limited number of transitional homes. Meeting the food and shelter needs of this population is an unimaginable task—to say nothing of addressing their

physical and mental health needs. How much of their illness is picked up only at the Emergency Department?

To be fair, the homeless problem is not only a health care issue, it is also a social issue. They are interrelated and must be addressed together. Nonetheless, our current system is hardly “health” care, but closer to “disease” care. According to the Medicare and Health Care Chartbook,¹ 40% of the health premium is spent on hospitalization, yet only 10% is spent on primary care. We treat people when they are sick, but not to prevent them from getting sick. Sometimes, we even forget to find out *why* people are sick. We depend on medications to control diseases like diabetes and hypertension, but we rarely asked why some people end up with these diseases. Surely, there could be genetic dispositions, but what about social problems, financial struggles, and educational opportunities that contribute to the manifestation of diseases? Perhaps “the wealthy being healthier than the poor” was not only because they had better access to our “disease” care system, but they also have the financial resources and educational background to learn about the necessary prevention that makes up for what the system lacks. If we deliver health education and preventive health care to this subpopulation, some underlying conditions could be treated more readily both medically and financially. I could not help but wonder if it would be more cost effective for the city, the state, and the nation as a whole if the focus were shifted to prevention.

When asked her views about the current health care system, Kathy was concerned about a government-run national health care system because “no one seems to agree on any one thing and it just takes forever for a decision to be made.” The main issues for Kathy are the high premiums and the scary costs of medication. Kathy feels that only physicians should be involved in decision making about the delivery of health care.

On the first day of medical education, I took the Oath of Geneva. I vowed that “the health of my patient will be my first consideration” and I “will not permit considerations of religion, nationality, race, party, politics, or social standing to intervene between my duty and my patient.” Physicians, by definition, are advocates for their patients. When we care for a patient, we try our best to relieve his or her discomfort using all available resources. When no financial problem prevents the clinic’s doors from opening, we gladly treat anyone in need of our services. However, in this ever more technology-driven health care system, diagnostic devices and treatment modalities cost a tremendous amount. When physicians can no longer fulfill the needs

of patients, they turn to public and private resources for support—one of which is pharmaceutical companies. Most pharmaceutical companies have community benefit programs to help needy populations.

Ironically, the assistance Kathy receives is probably funded in part or in whole by the very pharmaceutical companies that set the unaffordable prices that cause her frustration. Pharmaceutical companies are in the delicate position of profiting on the misfortune of others, yet their efforts to make new and improved medications and disease treatments are indispensable. Hundreds of thousands of scientists work for these companies, not to become millionaires, but in hopes of curing diseases and relieving suffering. As an undergraduate bioengineering major, I worked on a drug delivery project with a post-graduate doctor who received funding from a pharmaceutical company. The only thing that got me through the boring days of lab work was the hope that one day this machinery would work and HIV might be eliminated, patients with diabetes might have a better quality of life, and septic patients might hold a better prognosis. Perhaps “do well by doing good” was true for some or most pharmaceutical companies.

Pharmaceutical companies must continue their support for the scientific research. Physicians must continue to filter information distributed by sales representatives. As Walt Whitman wrote in the *Leaves of Grass*, “You shall no longer take things at second or third hand, nor look through the eyes of the dead, nor feed on the spectres in books ... You shall listen to all sides, and filter them for your self.” We can only diagnose a murmur when we hear one. We come to a conclusion only on the basis of evidence. Part of our education is learning the skills to discern the quality of information we are given and to act accordingly.

As I reread the Oath of Geneva, I feel privileged to be entrusted by society to carry out such a sacred job—along with this privilege comes responsibility. Despite my belief that health care is a right, I cannot ignore the fact that a subset of our population doesn’t have the chance to exercise this right. I must acknowledge that if I cannot change the system, I must learn to work within it. There may be a way to practice medicine in the imbalanced system by holding strong to our morals and beliefs. ♦

Reference

1. The House Committee on Ways and Means. Medicare and health care chart book [monograph on the Internet]. US House of Representatives 1999 May 17 [cited 2007 Jan 17]. Available from: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=106_ways_and_means_committee_prints&docid=f:wm004.wais.