

Teflon and Thistles

By Paul Mahon, MD – Healthcare for the Homeless, Manchester

In the past two weeks, two of our clinic patients died. Both were men in their fifties. This is a sadly routine occurrence in my office at Healthcare for the Homeless in Manchester, NH, a primary care clinic housed in the basement of our city's shelters but run by the Public Health department. I have worked there since 2007 as a family physician. I've long known what the research shows: If you are homeless, regardless of your age, gender or location, your homelessness alone increases your risk of death.

However, when I reviewed these two patients' charts, I learned something that I found even more disturbing. In all the years they had been enrolled in the practice, neither man had seen any doctor or nurse practitioner in our clinic more than once. Their medical records chronicle many street visits conducted by the outreach nurse and health educator, as well as dozens of visits to our hospital's emergency room—visits that were often followed by a phone call from the ER management pleading with us to better connect these men with medical follow up and primary care better delivered in an office setting. Although they weren't refused care, which would be illegal under federal law, the hospital staff did not welcome having to meet these patients' non-emergent and chronic health care needs.

The emergency room staff requests are rational, but there are many reasons why it's not easy for my colleagues and myself to do what they are asking. For one thing, we must overcome homeless patients' reluctance to come to the clinic for their basic medical needs.

At Healthcare for the Homeless, we try all sorts of ways to entice our patients to come to clinic. We distribute bottled water in summer and clean socks, hats and gloves in the winter. We give them crackers and peanut butter snacks to tide them over during the long stretch between breakfast and dinner at the shelter. We distribute samples of the most commonly needed medicines and personal use items like toothbrushes and facecloths. Even with these tokens, we still find it difficult to capture these patients. They defy our best measures. They're like Teflon; nothing attaches to them and they struggle to attach to others.

I suspect one source of their reluctance to enter our doors is the gauntlet of questionnaires and forms they must fill out just to enroll in our clinic. All of these forms are required by federal law annually to gather data. Every grant dollar donation we receive is paid for with paperwork, usually in the form of data collected about the people we see: How much schooling was attended? How many years of incarceration if any? How long has homelessness been a problem? Many people balk at the lengthiness of the questions which may take longer than the actual face time with a doctor. The questions about sexual orientation and practices of children in our immigrant populations are not crafted with a sense of cultural sensitivity. The war

refugees whom we see do not as a whole admit to sexual trauma, which some have undoubtedly suffered. These questions alone I see as a barrier to healthcare.

Another physical barrier that encourages our Teflon patients to slide away is that our clinic door is locked and requires admittance via a buzzer system. This is a reasonable response to the real safety concerns in our workplace. At another local shelter, an employee was murdered by a transient resident. Two years ago, there were gunshot murders outside the shelter where my car is parked. But still I see the locked door as a mixed message; we welcome the patients with one hand and push them away with the other. With the constraints of not owning the buildings in which we provide healthcare, this dilemma is currently insoluble.

There is also the harsh reality that homeless patients are traumatized people. As one shelter case worker said, "People don't end up in a shelter due to bad luck alone." In almost every case, there are elements of mental illness and substance abuse that impair the person's ability to maintain housing, jobs, or even the safety net of family. These same issues are caused by or may cause self-imposed social isolation.

"Social isolation is a growing epidemic," Dhruv Khullar,, MD said in the New York Times. No one exemplifies this as much as the homeless. Whatever painful circumstances led to their condition, the patient adopts habits that drive society away: never bathing, never changing clothes, public intoxication with a side order of angry outburst. Nothing drives a well-intentioned social worker away like fecal incontinence in clothing worn for days or weeks on end.

I look at our patients' charts and wonder what we physicians could do to become more like thistles, those large prickly seeds that attach to your trousers and socks when you walk through fields and woods. Somehow, I believe, we need to become like seeds quietly sticking to our patients so that they carry us along without even noticing.

My own dearest memories of receiving hospitality feature not fine hotels or dining rooms, but rather places that radiate personal warmth. It's my sense that the same holds true at Healthcare for the Homeless: a successful caregiver-patient relationship arises from an atmosphere of hospitality rather than from the service provided

In my own day to day dealings with patients, I find that asking them about themselves and giving them the opportunity to tell their stories is a powerful way of offering hospitality. I never start visits with a litany of questions about organ systems or illness. Instead, I ask questions like "Where are you from?", "How did you come to Manchester?", "Where did you go to school?", "What kind of job did you work?", "Tell me about your family".

I am constantly searching for common ground with my patients and for the connections that can be made. The stories our patients tell us are their gift to us. When we health care workers provide all the gifts, our patient relationship is no longer balanced. The gift receiver becomes indebted. I think some homeless patients try to avoid that kind of debt in anything more than a transient relationship.

I'm aware that this is not the model in many traditional doctor's offices. The business of medicine and its fifteen to twenty minute office visits does not support the kinds of social interactions necessary to construct a relationship with anyone. I do not see physicians or midlevel providers building patient relationships in the way businessmen build a relationship with customers. Ironically, as medicine has become more commercialized, the relationship building side of doing business is one of the few things that hasn't transferred. But relationship building, as important as it is to good caregiving for any group of people, is even more vital to delivering healthcare to populations such as homeless. Otherwise we will continue to see overutilization of Emergency Rooms with its high cost medical care, where health care relationships remain anonymous and socially isolating, as the norm for our homeless patients.