At ease in the Downtown Eastside: One family physician's perspective

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John leaned quietly on the side of the building on one of the side streets near Main and Hastings, smoking his cigarette and staring distantly when I walked by during my lunch break. He looked gaunt and weak, but not short of breath considering his advanced small cell lung cancer. His long grey hair and beard betrayed his relatively young age—he was barely over his fifties. He recognized me immediately and extended his hand, palm thickened with callus from a lifetime of physical labour and rough life in Vancouver's Downtown Eastside neighbourhood. His grip was firm and warm, but bony. He smiled and said, "Hello doctor," in a weak but genuine voice. He coughed, like most smokers do, but it made him even weaker and more short of breath. I asked if he was doing okay, if he had any breathing problems; but despite apparent dyspnea, he said, "No." His response did not surprise me. His denial, unlike others dying of advanced lung cancer, was not a means of self–preservation but a result of schizophrenia, which had taken hold of his life long before smoking likely caused his cancer. Like many of my patients, John was alone and had no contact with his family and virtually no other support network.

Marginalized populations continue to disproportionately utilize our healthcare services, with poor health outcomes in Canada.[1] Homeless and marginally–housed people continue to suffer from higher disease burden and will likely die earlier than the general population.[2,3] Numerous studies have identified leading causes of morbidity and mortality among this population, including trauma, cardiovascular diseases, HIV, hepatitis C, mental health, addictions, and injection drug–use.[3,6]

Vancouver's Downtown Eastside (DTES) includes some of the city's oldest neighbourhoods. For decades, it has been home to tens of thousands of people who occupy the lower socioeconomic stratum with a disproportionate representation of single men, the elderly, immigrants, at–risk youths, and those who have been incarcerated.[7,8] While the population in the DTES is extremely diverse, there are many common challenges, such as mental illness, substance use disorder, poverty, homelessness, and marginalized housing.[7,8]

Unfortunately, traditional approaches to medical care delivery have failed to improve the health status of these patients.[5] This is exemplified by the HIV epidemics during the early to mid 90's that rivalled sub–Saharan African countries.[9] While much progress has been made to improve access and quality of care-including concerted efforts to create a more patient–centered, community–based, and multidisciplinary model of care — more is needed.[8]

Providing services for patients in the DTES can be challenging as many of them suffer from past trauma and abuses, while many more continue to face ongoing suffering. Trust in physicians can be difficult to gain, with episodic care and sometimes demanding, manipulative, or violent patient behaviours.[10] Eliciting a reliable medical history can be trying due to language/literacy, mental health, and addiction challenges. Often, physicians need to take extra time to collaborate with other care providers to verify or gather collateral information to assist in clinical decision–making.

A sensitive facet of serving the DTES population is balancing the physician's responsibilities to their patients with the physicians' professional and ethical standards. To achieve this, it is crucial to use a flexible and pragmatic approach without compromising the standards of care. Not surprisingly, effective and empathetic listening skills become even more paramount when trying to decipher what is real in the history and what is not, as well as when collaborating with patients to come up with a pragmatic

and sensible plan to address their needs. Specifically, a trusting, therapeutic relationship can be established using communication that is at a level appropriate for patients' ability and capacity, a delicate use of medical terms in history–taking that avoids jargon, and a genuine interest in their concerns.

To reduce the stigma associated with patients' illnesses, particularly with addiction and mental health, physicians need to recognize not only their own biases and values, but also the emerging evidence that addiction is a primary, chronic disease of the brain's reward, motivation, memory, and related circuitry. Regrettably, the medical system and society at large continues to treat these patients with preconceived ideas, assumptions, and judgments. Therefore, ethically speaking, the motivation to provide care for the heroin addict who relapsed should be no different than that for the poorly–controlled diabetic patient who failed oral hypoglycemic agents.

Meaningful advocacy is another important skill physicians can leverage to overcome barriers to care for DTES patients. With increasing demands for the assortment of outreach services provided by the regional health authority, partnered non–profit organizations, and peer groups, physicians need to be actively involved in advocating for equitable services not only for those who can communicate their needs, but also for those who often suffer in silence as a result of negative symptoms of mental illness, stigma, or discrimination associated with their illnesses. In particular, advocacy requires physicians to step beyond their role as the medical expert and become involved in activities such as attending discharge planning meetings, liaising with other community health services, and leveraging support for timely access to other resources. Different care providers and services—from wound care, medication administration, and homecare/home support visits to outreach visits by physicians, nurses and nurse practitioners—need to collaborate to provide more effective clinical care, case management, disease prevention, and health promotion to avoid the traditional silos of care between hospitals, private offices, and community organizations.

Given the intense nature that is the DTES, it can be daunting for compassionate and well-meaning practicioners and medical learners to feel confident and competent enough to provide sustainable care for their patients. To avoid burnout, physicians need to be mindful of their well-being and develop resilience. Dealing with stress is an essential skill to foster, particularly in those who bear witness to loss, grief, trauma, and suffering. Practicing regular, interactive (external) reflection and empathy can prevent and cure cynicism and exhaustion.[11] Recognition of one's "red flags" is also a crucial skill for all learners and practitioners to develop. The old adage of "physician, heal thyself" reminds us and our learners to not ignore our own needs and to maintain our physical, emotional, and spiritual health.

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Despite the seemingly daunting task, caring for patients in the DTES is not necessarily different from those who live elsewhere in Vancouver; however, it does require physicians to be mindful of the specific skills and strategies that are required for a more impactful therapeutic relationship in this neighborhood. Fortunately, many of these skills were grounded from my family medicine training, while many more were learned (sometimes frustratingly) on the job. Despite all the challenges, I take comfort in the thought of being surrounded by like–minded people, and I witness humanity and dignity every day—with that, I feel at ease when I walk the streets of the DTES.

I visited with John for a few more minutes on the street as he was clearly having trouble maintaining a prolonged conversation. I shook his hand again and wished him well. He thanked me for stopping by to say hello and for the care I gave him. A week later, his case manager told me that John died in his sleep peacefully in his room at May's Place (hospice). It had been less than 3 months since I first met John and I took comfort that he lived his last days with dignity and free of pain, and that I had played a small part in it.

disclosures

Dr. Yau has no conflicts of interest to disclose.

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