

on the street and make eye contact with TJ's mom, then keep walking. I saw trash scattered in the small overgrown front yard. But I also saw TJ smile the entire time I was there, move from his mom's lap to mine, and start calling me "brother."

Over the next two years, TJ and I went out nearly every week. We did things that he had never done before. Eating seasoned crawfish while watching planes take off and land at the airport was something he loved to do. But the activity that trumped all else was bike riding. We would often drive thirty minutes outside the city to some wooded area with trails, and ride bikes "off-road," all the better when other kids were there. TJ regularly became the leader of the group, and whenever anyone would fall off his bike, he was always the first to jump off his to help. Although I had explained a hundred times over that I worked in a research lab with no patients, he would without fail tell the child that his "brother" was a doctor and everything would be okay.

Taking TJ home was always easy. He slept the whole ride home every time. Dropping him off was never easy. I knew he was returning to a home with a poorly-working refrigerator, that frequently lacked electricity, and routinely had illegal drugs. As I found out over the years, these details, coupled with an endless love for his mother, defined his home life.

I'm not sure when it actually happened, but sometime in the two years we spent together I eventually stopped feeling pity for TJ and his mother. What started as a commitment based on feelings of sorrow for my little brother turned into an experience that forever changed us both. It made me see beyond the disease, his mother, and his home. TJ was a boy who, despite life's circumstances, still radiated love, happiness, and innocence. Even though his small body harbored a rapidly multiplying virus, he was first and foremost human—as were the patients I had initially pitied in the clinic.

I no longer treat any patient with pity. I have replaced it with heightened levels of empathy, understanding, kindness, compassion, and above all, solidarity. For a long time, though, I questioned myself about this. Was I right in doing so? Doesn't pity have a role in medicine? Certainly the less fortunate could benefit from pity!

A few years ago I sat in the Haitian countryside with some of the poorest people in the Western hemisphere. I often ask patients what advice they would give me as a medical student so that I can become a better doctor, a better person. When asked what advice he would give doctors wanting to come to Haiti, one of the men said, "We, as poor people, want your help. We do not want, nor do we need, your pity. Pity will not help us."

TJ is now thirteen.

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Perspectives

Discharged to the streets: Who cares?

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Recall the face of the poorest and the weakest man whom you may have seen, and ask yourself if the step you contemplate is going to be of any use to him. Will he gain anything by it? Will it restore him to a control over his own life and destiny?

Mohandas K. Gandhi¹

Mr. Ruiz was well known to me from previous psychiatric hospitalizations. This time, however, he was only partially clothed and covered in feces. His rambling speech was so disjointed it was incoherent. The police had brought him to the emergency department after coaxing him from a rain-soaked box leaning against a dumpster behind an abandoned restaurant. In his early forties, Mr. Ruiz looked decades older.

From what I could gather, he had been living in his cardboard shell for nearly ten days following his release from a local inpatient psychiatric facility. When I spoke with the



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psychiatrist responsible for Mr. Ruiz's treatment and discharge, the doctor coolly reported that it really was not part of his "job" to find housing for people. Moreover, he quickly added, Mr. Ruiz "chose" to return to the streets rather than go to a local shelter for homeless persons.

Mr. Lancaster, on the other hand, was an elderly man bearing an uncanny resemblance to a mildly-confused Santa Claus. I met him on my weekly ride-along with a street outreach team attached to our city's homeless center. On these search-and-find excursions, two case managers and I scour the streets and surrounding woods to locate and engage homeless persons in need of medical and/or psychiatric care. We make arrangements for those with medical needs to be seen in our shelter-based psychiatric or primary care clinic. We always look for ways to bundle shelter and food with the medical services.

In the breaking dawn light of this particular day, we came across Mr. Lancaster lying in a dark, garbage-strewn alley that snaked behind a homeless shelter. His legs were crudely wrapped in dirt-caked gauze dressings and soaked through with urine. On his wrist was the hospital identification band that recorded his name and birth date. He was seventy-seven years old. Prior to our encounter he had been admitted to a local hospital for several days, where he had received inpatient treatment for an angry, oozing cellulitis covering his lower legs. Upon discharge on a late Sunday evening, he had been given a cab voucher with instructions to the driver to take him to the nearest shelter.

After being dropped off by the cabbie, he realized he had missed the admission curfew. When we came upon him he had spent the previous twelve hours lying in the gravel of the alley, unable to stand, calling for help but unheard and unnoticed.

Next to him was a large plastic bag filled with sterile gauze wrappings and rolls of medical tape. Before leaving the hospital the previous night, he had been given written instructions to change his bandages once a day, fill his antibiotic prescription, and be scrupulous about keeping his legs dry and elevated. Once we got him bathed and situated at the shelter, it became painfully obvious that dementia had robbed him of a trustworthy memory and a reliable set of problem-solving skills. The written instructions were not only useless but—tragically—comical in light of his state of homelessness and confusion.

I would like to think that a homeless mentally-ill person being discharged from a hospital unit to a city street is an exception to the norm. I would even like to believe that these particular adverse events are usually the result of administrative oversights that are always seen as serious and humanly painful mistakes. But as a psychiatrist who has worked with homeless persons for two decades, I know better. More times than I care to recount, the "choice" to return the person to the streets arises not with the homeless patient but rather with the treating physician.

I believe we can do better. A covenant of care implies that our moral commitments and professional instincts are singularly "focused upon individualized and excellent care of the patient."² Because our professional positions grant us visible moral standing in society and a clarion voice in medical institutions, we are uniquely privileged to be both the providers of medical care and advocates for needed compassionate services.

Homeless persons who enter the health care system with broken minds and damaged bodies invariably need more from their doctors than medical care alone. And physicians who find themselves in the position of caring for those who are "the poorest and the weakest" persons in our communities, may often struggle (as did William Osler) to "maintain an incessant watchfulness lest complacency beget indifference, or lest local interests should be permitted to narrow the influence of a trust."³ At the end of the day, however, the "choice" to care deeply, to prevent suffering and to never abandon a patient rests always with us.

References

1. Iyer R, editor. *The Essential Writings of Mahatma Gandhi*. New Delhi: Oxford University Press; 1990: 418.
2. Harris ED Jr. Professions, professionalism, and covenants. *Pharos* Summer 2006; 69; 1.
3. Silverman ME, Murray TJ, Bryan CS, editors. *The Quotable Osler*. Philadelphia: American College of Physicians; 2003: 7.

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