



Experience

Expérience

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The poor are different from you and me

Caroline Despard, MD

There's a medical student in the office today and we just saw a woman with pelvic inflammatory disease. We reviewed the guidelines for treatment and came to the catch — she can't afford the treatment. Catches like this are common in my office, so off we go to the sample room to try and cobble together a reasonable alternative.

I treat the working poor, refugees and immigrants. Many of these patients are on welfare or receive disability payments, and every day I see situations where socioeconomic status dictates treatment, particularly when it comes to drugs.

We have the Ontario Drug Benefit (ODB) for seniors, disabled people and those receiving welfare. We also have the Trillium plan for patients facing huge drug costs because of catastrophic illness, but there's a deductible. This week an AIDS patient told me he'll be stopping all treatments designed to suppress the disease because his application to Trillium and the supporting documents have been lost — again.

I probably know the number of every drug company's "compassionate drug" hot line. I know their criteria and have all their forms, and every day I write to one of them or to the ODB seeking "special permission" to use nonformulary drugs. Several times a day I fill out forms for "limited-use" access.

Treating with samples

For the poor, access to appropriate care can be thwarted in so many ways. For several months, "Gillian" hasn't been able to afford Ontario's new \$2 fee for filling prescriptions provided under the ODB, and she can't visit any of the pharmacies that are waiving the fee. To visit one of them would require bus fare she doesn't have. Her cholesterol and blood-pressure levels are high and she admits that she isn't following her prescribed diet. This week she's eaten nothing but mayonnaise sandwiches, the only food she had. Patients like Gillian are the reason I keep a list of local food banks handy. I changed her hypertension medications several times within a few months — I'm treating her with samples — and eventually we got over the hump.

Today, a recent widow who is receiving Mother's Allowance arrived with her 4 children. She doesn't speak English, so either one of the children speaks for her or we borrow an interpreter from the local pharmacy, if one is available. One of her children has asthma and needs an AeroChamber. (Sometimes the drug company provides samples, but there are never enough so I try to reserve them for the most needy.) These devices are not covered by the ODB, so she must apply for coverage to a special branch of the Ministry of Community and Social Services.

This woman who speaks no English must take my note saying the device is needed and go to her pharmacy to get a written quotation on the price. Next she must board 2 different buses with 4 children in tow — I'm assuming that she can afford bus fare this month — and go to the correct ministry office to explain what she needs. She then receives a voucher and returns to the pharmacy, where she will get the AeroChamber. I am assuming, of course, that her 8-year-old daughter can explain all this to her.

Things they don't teach in med school

Sometimes speaking the same language isn't enough. Many of my patients are illiterate in English, and this means that interpreting and responding to letters



from insurance companies or welfare workers is another one of my jobs. Every year the local public health office sends immunization forms home with students. Students are threatened with suspension if the forms are not completed by a specific date. Most of the children are in fact immunized — I've learned that immigrants are pretty good at complying with this because they've seen many of the diseases in question firsthand — but their parents don't fill out the forms because they can't read them.

One female patient was in a motor-vehicle accident but hasn't received any treatment for her neck injury, and her husband's insurance company won't pay until he sends them a letter stating that he gave her permission to use his car that day 9 months ago. Neither of them can read the letter, so I write a response and he signs it.

Many of us use pamphlets to reinforce the messages we are trying to convey. Unfortunately, we need more creative solutions for illiterate patients or those literate in languages other than English. I've started looking for pamphlets with good illustrations and constantly ask drug company reps to have their brochures translated. My collection now includes Vietnamese-language pamphlets dealing with birth control, immunization, HIV and hepatitis B and C. My office even has a recall notice in Vietnamese that reminds patients about overdue appointments or interventions.

Level V evidence

I try to teach my students and patients about preventive care. When I graduated from medical school I thought I knew what this meant, because I had won the OMA prize in this area. Today I define preventive care as making sure children have proper boots and mitts (frostbite prevention, level V evidence).

Many things limit access to the usual preventive care, but these topics are seldom deemed worthy of discussion in our journals. Some of my patients, new arrivals to Canada, have never had Pap smears, and so they can't understand why they are needed. For various reasons, many even have trouble getting to my office.

Chaos rules many of my patients' lives. Due to combinations of factors — drug and alcohol problems, poverty, lack of family and social supports, abusive relationships, psychiatric problems and a lack of safe or reliable housing — their day-to-day lives bounce from one crisis to another.

Rides or interpreters fail to show up. The school reports that the children are having problems. A relative gets in trouble with the law. A friend or family member dies suddenly. The only constant is new emergencies, and their priorities are seldom the same as their doctors'. If you're not sure where you'll be living next week, concerns about cervical cancer tend to take a back seat.

Many of my patients don't eat very well, mostly because they cannot afford to or due to a misunderstanding of dietary needs. They are less likely to get adequate fruits and vegetables and more likely to eat more fat and salt and be obese. They are more likely to smoke and to have more chronic health problems.

For my patients, the difficulties start early. Prenatal care is limited because of the access problems already mentioned, and children are less likely to be breast-fed. By paying more to bottle-feeding moms than to those who breast-feed, our social service system actually undermines public-health efforts to support breast-feeding. Many of the children receive 2% milk as early as 2 months of age. Ever seen a hemoglobin of 56 in an otherwise healthy 6-month-old infant? The baby was receiving 2% milk and boiled rice. In this case, a misunderstanding of the infant's needs and a cultural tendency to feed rice instead of fortified infant cereal made of rice was the cause.

Prescribing Crisco

Here are some stories of life within our one-tier health care system.

"Becky" has probable attention deficit disorder and her mother has requested testing. If Becky were my daughter I'd simply hire a private psychologist for \$1000 or so, but Becky will linger on the local waiting list for 9 months.

At 2 years, "Joseph" says only 3 words. If he were my son a private speech therapist would be seeing him next week. Instead, he will be seen in 9 to 12 months by the provincially funded speech therapist.

"Henry" hurt his shoulder playing football. His low-paying job doesn't include benefits, so he'll wait for provincially funded physiotherapy that should begin in about 6 weeks; private treatment could have been arranged for him this week. In the meantime, he's in pain and unable to work, so his family will go to the food bank.

"Janice" has 3 children and an abnormal Pap smear. Her husband is in a low-paying job and the local specialist won't see her with the children in tow. She has no other friends or family to turn to for help.

"James" has low back pain. When he was working and had health benefits he visited a chiropractor and did very well. Last year he was laid off and he can no longer afford those treatments. All other modalities we have tried haven't worked.

"Mary" arrived this evening in terrible pain. I'd been out of the office delivering a baby, so she'd waited a few hours because they had no transportation to the hospital. She had a dental abscess and her parents, being new immigrants, did not know that the government covered dental services for children whose parents were receiving welfare. The dentist at the end of the hall stayed late to see her.



“Terry” has severe eczema involving all her body surfaces. Moisturizers are no longer covered under the ODB and her parents cannot afford them. The ODB’s special request section informs me that it won’t make an exception for her and recommends that she use a low-cost alternative — Crisco. I’ll alert the food bank to get in extra.

“John” missed his appointment with the specialist, who is now questioning his compliance and refusing to see him again. John didn’t go because of any of the following reasons: no money, no interpreter, no babysitter, a low-paying job that he could not leave, no transportation, no understanding of the instructions he received or a treatment plan that was not consistent with his cultural expectations of health care.

A few specialists refuse to see people who need interpreters, and others rely totally on voice mail. When the interpreter is standing in my office with a patient who has no phone and needs to see a specialist for gastroscopy because of a gastric ulcer, there is nothing more irritating than voice mail!

It’s only \$15

Some patients have no health insurance card, a problem that is more serious now because failure to produce a valid number may mean that care is denied. To get a card, applicants must have adequate identification. A birth certificate is preferred, and to get one they must go to the courthouse (2 different buses), fill out a form and mail it, along with \$15. After waiting a further 6 weeks for the document to arrive, they once again take the bus to the insurance office. Most of my patients without coverage

are young people who have never worried much about their health, or people with major drug-abuse and psychiatric problems who find the signing-on process impossibly daunting.

The students I teach often seem overwhelmed by the problems they witness and ask me how I cope. First, I acknowledge that no one can solve all the problems and that the problems are theirs, too — not just mine. Second, I tell them of the great enjoyment I get from the little things I can do to improve my patients’ health. One gentleman from Somalia is wearing a very nice winter coat thanks to one of our local internists. (Thanks, Brian!) Finally, most of my patients are great people. It sounds corny, but from their chaos emerge wonderful stories of strength and character.

That’s my final message to the students — see the people, not their problems. Despite their difficulties, these patients are among the most giving, humour-filled, gracious and, yes, tragic people I have met in our society. Each year my family is honoured to be invited to the annual Tet festival to celebrate the Vietnamese New Year. My daughter recently joined a school stamp club and, realizing that many of my patients received mail from relatives overseas, I posted a notice asking for any unwanted stamps that come their way. Every day I received stamps, sometimes stuck into welfare medical forms, sometimes in envelopes, sometimes in small thank-you cards.

I tell my students to change what they can and to fight like the devil to overcome inequalities and gain access to treatment for their patients, no matter who they are. And, ultimately, I remind them that the poor will always be among us. ?



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