

Tattered slippers

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He was 31 years old when he died — much too young — from a mostly manageable chronic disease.

At 18, he had started working at a fast-food restaurant and was proud he was becoming self-reliant. In those years, we talked about harm reduction. He had type 2 diabetes with an insulin pump and a horrible family history of diabetic complications. Could he stop smoking? Or cut down? Could he eat foods that did not spike his blood glucose? How about a walk once a day? He checked in regularly and made some progress.

At 25, he lost coverage for his insulin pump and struggled to pay his bills. Eventually, like many young folks in Newfoundland and Labrador, he moved away for better wages. I did not see him for several years.

When he was 29, I saw him in my waiting room. “Hi, Dr. P., I’m back for a while.” I did not recognize the young man before me except for his voice. He was cachectic and haggard, having lost half his body weight. He had a constellation of nonspecific symptoms and signs. I knew he was sick. He requested help for back pain that was now preventing him from working.

Surely he had a life-altering disease such as cancer. Was it multiple myeloma? Vertebral fractures from metastases? We sent him for investigations. Lumbar x-rays, thoracic x-rays and a bone scan showed only an old rib fracture; he had no metastasis, osteolytic lesions or compression fractures. His albumin level, blood count and serum protein electrophoresis were normal. The only exception was a hemoglobin A_{1c} level over 15. Was there an obscure cause for his symptoms? Internal medicine said a lack of insulin had led to wasting and sarcopenia, contributing to back pain. I was astonished. In my 20 years of practice, I had never seen such a dramatic consequence of poor diabetes

management. He later admitted to stopping all his diabetes medication. His job did not offer medical insurance and the high cost of living put the cost of medication out of reach.

We discussed resuming diabetes medication. He was resistant even though he understood the long-term sequelae of diabetes; many of his family had diabetic complications. “I just need something for my back.” We compromised and gradually restarted metformin. Then an ACE inhibitor. Then a statin. His medication list climbed into the double digits. He took each prescription form from me but picked up only a handful from the pharmacy. I helped him apply for low-income drug coverage, but it took time. There was also a 6-month wait for hospital-based physiotherapy. We aimed to get him back to work, maybe as a cashier or fast-food worker. But each time he came to the clinic, this goal seemed further away as he continued to experience back pain, weight loss and weakness. Finally, the goal was insurmountable, so we arranged income support.

He liked the weight loss and did not want to start insulin, despite A_{1c} levels in the teens. An acute kidney injury soon followed. His urine albumin-to-creatinine ratio topped 1200. Then came diabetic nephropathy, which led to hypoalbuminemia and massive anasarca. He was only 30 years old.

As his health deteriorated, so did his tenuous social situation. The government helped him with affordable housing, but it was far from his friends and my clinic. I helped him arrange accessible transit. He now had access to the provincial medication program but struggled to pay for some medications that were not covered, such as diabetic testing strips. He received help from the community food bank.

Then he stubbed his toe. A small injury. “Nothing to worry about, Dr. P.” The minor injury slowly worsened until it became a diabetic ulcer, which became osteomyelitis of his great toe. It was débrided. He received long-term IV antibiotics. But like its owner, that toe was stubborn. It resisted treatment. Amputation was discussed. This young man I had known for his entire adult life rapidly declined.

I started doing house calls and brought family medicine residents and medical students along. His new apartment was clean and safe. We encouraged him to take a daily walk down the street to check his mail for fresh air and exercise. He lived in the capital city, so the accessible transit bus took him to his many specialist appointments and regular investigations.

But the osteomyelitis worsened. Trips to the grocery store became difficult, so he bought canned food from a neighbourhood convenience store. Winter approached, and with it came sleet, freezing rain and blustery Atlantic winds. His mental health suffered from isolation, loneliness and defeat.

The last time I did a house call, anasarca had robbed him of his ability to wear shoes. Someone brought him an old pair of slippers to wear around his house. The slippers were worn and threadbare. The ulcer drained through one of the slippers, painting it with a kaleidoscope of stains. He told me that, most days, he moved only when necessary to get a cup of tea or to use the washroom. He scuffed those tattered slippers across the carpet to show me to the door.

Eventually, he agreed to return to the hospital for an amputation. However, by this point, his health had deteriorated too much. His kidneys were failing. His electrolytes were unstable. Edema was enveloping

his lungs. Then came sepsis and multiple antibiotics. Then maybe a little clot went to his lungs. Or perhaps it was hyperkalemia. Or possibly heart failure. He was moved into the ICU, where he died.

Thirty-one is far too young to die from diabetes.

How could our health care system have better helped him? If only he had shoes. And healthy food. And affordable medications. What if his family had been closer? Would a patient navigator have made a difference? What if he could have kept his insulin pump after age 25? Maybe participation in a structured program for smoking cessation and exercise would have helped. What if he had a psychologist to address the trauma of seeing his parents endure multiple amputations? What if he had a social worker to help navigate his finances?

I now honour his memory by telling his story to medical learners as we care for similarly marginalized patients. It is

becoming increasingly challenging to tend to more complex patients with worsening social determinants of health using thinly stretched resources. His health care team did everything possible to help him but could not treat his primary diagnosis — poverty. Society may place part of the responsibility on him; he could have chosen healthier foods, strengthened his back at home and used smoking cessation therapies. There is an implicit bias that those living in poverty need only work harder to improve their situation, but what if society shared more responsibility? What if there were smaller grocery stores within walking distance that had lower-cost, healthier foods? What if our cities and towns focused more on exercise, nutrition and fostering community? We as physicians need to consider our own implicit bias toward poverty; we are privileged to help our disadvantaged patients at their most vulnerable moments. Healthy food, appropriate

clothing and safe housing are foundational needs each Canadian deserves, along with access to medical care. The more we bring our voices together, the louder we can be. Canadians should not needlessly succumb to treatable chronic health conditions when their lives are only starting.

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This article has been peer reviewed.

All details that could potentially identify this patient have been changed.

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