Reflections

Working the inner-city trenches

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It is 11 months into the job. I wake up and feel that I cannot go to work—but I go. I have to go. I have people who need their medication, their wounds bandaged, their stories heard, and their tears dried. I drag myself out of bed, throw myself on my bike, and hope the wind will renew me again today.

I pedal down, down, down. As I come up the back alley to the centre, I look in the alcove to see that everyone is still breathing. I watch the pile of sleeping bags and crack pipes move up and down. I take a breath myself.

I sneak in the back door. But before I make it to the stairs, people move toward me. An outreach worker reports that one of our clients died this morning. A social worker informs me that another client is in jail for assault. As I try to steal away through a back corridor, a client grabs me to say he spent the night in an emergency department and needs to see me right away.

I finally reach my office where the telephone welcomes me with seven messages: a case manager from the local methadone clinic calling about our client admitted on a Form 1; the local women's shelter with a new referral; my supervisor about the need to bar a client from the centre; a call from another community agency asking for a letter of support for a new project; and a parole officer concerned that a diabetic client with coronary artery disease is not taking his medication.

Meanwhile, the waiting room is filling up for my Monday morning drop-in. Heather is sitting front and centre, looking anxious and fragile. She is fourth on the list, so I let her know I will be with her shortly. But she bursts into tears, and so I gently take her arm and bring her into my office.

Heather says her chest hurts terribly since her boyfriend beat her 2 days ago. They live in an alley and survive on her working the sex trade. She has snuck away to see me, terrified that he will discover she has told someone. Only several visits later will she begin to ask for help in leaving him. And then she will not return for months.

Feeling human is unfamiliar

John is next. He has been drinking since he was 13. He once recounted to me that, as a child, his father used to leave him alone for weekends with a case of beer. He drinks everything from beer to cooking wine to rubbing alcohol and mouthwash. He comes in twice a week

Canadian Family Physician invites you to contribute to *Reflections*. We are looking for personal stories or experiences that illustrate unique or intriguing aspects of life as seen by family physicians. The stories should be personal, have human interest, and be written from the heart. They are not meant to be analytical. Writing style should be direct and in the first person, and articles should be no more than 1000 words long. Consider sharing your story with your colleagues.

Dr Melnitzer *works at an inner-city community health centre in Toronto, Ont, as part of an interdisciplinary team that specifically serves homeless people.*

to have the dressings changed on his deep chronic wound and for counseling. I use the medical care as an excuse to keep him talking and connected. When I ask him how it felt during the 6 months out of the last 30 years that he stopped drinking, he says he felt "human."

But feeling "human" is scary and unfamiliar. Three days later, he comes in more severely intoxicated than he has ever been and agrees to go to a detoxification centre. It takes him 5 days to complete his withdrawal, and for the first time he is willing to speak of treatment: seeing an addiction counselor twice a week and helping out at detox. No inpatient treatment, no proclamations of abstinence—but a tiny dent in the bars of his self-destruction.

In the midst of the drop-in, the nurse practitioner I work with calls to say that we need to make a home visit. Alan is suffering from end-stage cirrhosis and refusing to go to hospital, but his belly has become so distended that he is increasingly short of breath. He wants to die at home, but his already filthy room is now littered with feces and urine. He is immobilized by his ascites and weakness and usually cannot make it to the bathroom.

At first it is hard to understand why he will not leave the place, but later, after his social worker, nurse practitioner, and I finally convince him to go to hospital, I begin to understand why home—any home—is better than hospital: the staff speak about him with disdain and condescension. His days as someone's son and as a highly skilled professional are not elicited when they take a social history.

Rough side of town

As I blast back to the centre from Alan's place, I take in this incredible neighbourhood, a place that just a few months ago I thought of only as "the rough side of town." I see my clients everywhere: on park benches, in bus shelters, wandering the streets talking to voices no one else can hear. I smile, reflecting on how at home I have become here and how much I have learned. I think of the intravenous drug users who teach me how to draw blood from their sunken veins and the sex trade worker who educates me on "john school."

These are people deep into the cycle of poverty, homelessness, addiction, and mental illness. Almost everyone has a history of abuse. Most are alienated profoundly from those around them and from themselves. Trust is critical for our relationship to thrive, and yet the opposite of trust is what enables them to survive on the street.

So I am privileged to be trusted. I am privileged to care for the folks who have not seen a doctor in years and who begin to feel the centre is a safe place to come.

And I am privileged to hear laughter. When I take a brief leave unexpectedly, I return to a crack-addicted client who puts her arm around me and says, "Honey, you had me so worried. I had a horrible nightmare that you were strung out on cocaine, and I came to visit you in rehab!"

Her caring lifts me, and I know that, despite the struggle, or maybe because of it, I will be back tomorrow.