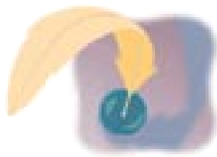

Marginalized patients

A challenge for family physicians

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Mary is a 22-year-old single mother on social assistance. She grew up with two brothers and a sister in a run-down house on the outskirts of town. Dependence on social assistance was said "to run in the family." Because Mary never had a family doctor, she relied on emergency and walk-in services for herself and her children. "Be careful not to encourage Mary to come back. We don't want *her kind* as regular patients in this practice." This advice to a new physician in the community (K.P.) highlighted the challenge of caring for those commonly referred to as "marginalized."

Our group, Physicians Alliance for Access to Care (PAAC), held a meeting during a blizzard in Toronto, Ont. While the plows struggled to remove the mounting snow, we discussed ways to remove the growing barriers to the health care system. The group, mainly composed of family physicians working in inner-city settings, has been looking for creative ways to promote effective delivery of primary health care to marginalized and vulnerable members of our communities. Our discussion and recommendations are based on the following assumptions:

- Core values of family medicine include accessibility, comprehensiveness, continuity, and coordination.[1]
- Accessibility can be defined as a group's potential and realized access to the health care system. It depends on three main components: financial, psychosocial, and spatio-temporal.[2]
- Although the health status of vulnerable populations depends, to a large extent, on economic resources, family physicians and other primary care professionals must help improve health care delivery to these people.[2,3]

Front lines of health care

Family physicians help form the front lines of the health care system, caring for patients with illnesses often made worse by social realities. The fourth Principle of Family Medicine is "The family

physician is a resource to a defined practice population." To do this, we must be advocates as well as resources for patients like Mary. This role offers insight, compassion, and rewards for the community and physicians but demands having a range of knowledge, skills, and attitudes.[4,5]

People might be considered marginalized due to lack of income, attitudes, mental illness, racism, complex health needs, lack of representation, and cultural or linguistic barriers. Unfortunately, these barriers often coexist with lower socioeconomic status and result in poorer health.[6-8] Health inequalities among this vulnerable population are well documented and exist across most illness categories. Higher morbidity and lower life expectancy are a tenacious reality for economically disadvantaged people,[9] even in our country, which professes to have universal and accessible health care services.

John lived for several years like a hermit. Sleeping and drinking in a cardboard tent, he had cheated the cold of winter. At 55 years of age, he was estranged from his wife and two sons and unemployed. "Being fired," he said, "changed my life. I can't explain what happened after that."

John was disheveled when he first walked into the clinic seeking care for multiple fractures after being beaten by a local street gang. John was living an isolated, lonely life. Now, after 3 years of supportive care, John is sheltered, safe, and rebuilding his life. Working part-time as a mechanic, he has reunited with his teenage sons and volunteers in an art therapy group for survivors of mental illness. He attributes his remarkable recovery to the help of housing, medication for his depression, social services, and an ongoing patient-physician relationship.

Diverse backgrounds

Marginalized people come from diverse cultural and educational backgrounds and have varying levels of individual need. Although many factors contribute to social situations, people are often considered personally responsible for choosing unhealthy lifestyles that lead to health inequalities. Health inequalities could become permanent and even span generations as we see in cases such as Mary's. As recently documented in *The Growing Gap: a Report on Growing Inequalities Between the Rich and Poor in Canada*,[10] impoverished people have continued to suffer. The responsibility of addressing the lower health status of vulnerable populations must be shared by governments, representatives from the groups involved, non-government organizations, physicians, and other health professionals.[2]

Struggling for human dignity, patients such as Mary and John battle against barriers created by the increasing disparity between wealth and poverty and educational opportunities. Parallels exist between marginalized people in our society and vulnerable citizens of poorer countries. Despite advances in wealth and technology, the health effects of poverty persist in all countries.[11] These shared health issues offer opportunities for countries to learn from each other. Great Britain, for example, has introduced "deprivation" payments for general practitioners, an additional stipend given for working with economically disadvantaged populations. British researchers are now attempting to measure the actual cost[12] and toll on physician morale[13] related to working in areas affected by poverty. A world leader in universal health care, Canada must continue to develop initiatives to ensure equitable access to health care based on individual need.

Our group began in 1996 when current health care reforms further threatened access to care for vulnerable members of our population. We are committed to advocating for inclusive, patient and family-centred, comprehensive, and continuous primary health care.

Recommendations

The PAAC makes the following recommendations[14] to help remove barriers to the health care system and to enable marginalized patients to receive the health care they need.

1. To recognize the vulnerability of marginalized groups, it is recommended that health care reforms and physician organizations reference and include the needs of marginalized communities and those of lower socioeconomic status appropriately and sensitively.
2. To recognize the need for innovative approaches to improve care to the marginalized, it is recommended that a working committee be formed for family physicians to promote research and develop strategies for working with marginalized groups.
3. To recognize the importance of knowledge, skills, and attitudes, it is recommended that educational programs for family physicians specify objectives that will provide appropriate training to work with these populations.
4. To recognize that a team approach is essential to facilitate access to care for marginalized

groups, it is recommended that a coalition with other health professionals be developed to facilitate on-going communication and working relationships among the health disciplines.
5. To recognize competitive reimbursement as essential to sustain physician resources, it is recommended that reimbursement models realize the complexity of care required for marginalized members of our community.
6. To recognize the importance of the family, it is recommended that an inclusive definition of the term family be adopted within the context of family medicine.
7. To recognize the role of family physicians as advocates, it is recommended that a fifth principle of family medicine be instituted: "The family physician is an advocate for the health needs of patients and communities."

We support inclusive universal health care that meets the diverse needs of our society. We are committed to removing barriers in the form of attitudes and compromising reforms that contribute to inequities of access to health care of patients such as Mary and John. We encourage family physicians to speak on behalf of marginalized patients.

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