Eyes wide open

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Family practice arguably is the most diverse practice in terms of medical illnesses and population demographic characteristics. Wealthy and poor, new immigrant and established Canadian citizen: they all walk through the office door. When caring for people from such diverse walks of life and ethnic backgrounds, one must challenge one's mindset to not give in to any preconceived notions. I recall the first thing that used to come to mind when I heard the word *homeless*. It was the disheveled woman with schizophrenia who walked down Yonge Street in Toronto, Ont, yelling at her demons and flailing at unseen ghosts. That is, until I had the opportunity to work in a homeless shelter.

It began with a tour of the shelter. I first walked into the common room. There were rows of chairs, a table at the back, and a television at the front. People were chatting, playing cards, and watching *CSI: Crime Scene Investigation*. It all seemed very normal. There was a cafeteria that looked oddly like a smaller version of my high school café and next to that was a chapel. In the lodging rooms were rows of bunk beds with little more than a few feet between them. And that was it. I learned that most of the patrons left during the day to go to work, to the library, or just to be out of the shelter. However, for some, the doors of the shelter were as far as they would venture. They would wake up and sit in front of the television all day, only leaving for a cigarette break.

I also had the opportunity to sit in on a residents' meeting, where the staff and patrons discussed issues arising at the shelter. Attendance was not high at this meeting, but it was clear that those who stayed had assumed responsibility for the building. They were interested and actively involved in what was happening at the shelter. They cared and wanted the best for the shelter and those who lived there. I did not expect to see such dedication.

As I learned about the patrons, I quickly recognized the diversity in the shelter. Some people had serious mental illnesses that had prevented them from completing school past grade 6 and essentially doomed them to lives of poverty. Some were immigrants who found that their skills and education were not as transferable to the Canadian economy as they had hoped. On the other end of the spectrum were those who had completed university degrees, including graduate and professional degrees, and for one reason or another had fallen on hard times. This was astonishing—how even those who had the privilege to pursue higher education could be reduced to homelessness.

Now when I think of the homeless population, I try not to let any one image surface. It is all too easy to allow a preconceived idea to cloud an opinion. Saying that I am white tells you very little about what kind of person I am—that same logic should be applied to the homeless population. Does the disheveled woman with schizophrenia exist? Yes. However, so does the lawyer who lost himself to gambling and is trying to turn his life around. They are all unique and deserve respect—deserve to have others look beyond their labels.

In practice, it is important to keep this notion in mind so that one does not make false assumptions about patients. A homeless man might be a smoker, but one should not assume that he has no interest in quitting simply because most of the homeless population shares the same addiction. If anything, this should make the homeless man one of the primary targets of smoking cessation efforts. However, this can only happen if one looks beyond the label of "homeless." As an aspiring family physician, I see family medicine as a field uniquely suited to exploring these issues. But this is the challenge of becoming a family physician—being able to see the person and not just a diagnosis.

Dr Gilchrist is a first-year resident at the University of Toronto in Ontario.

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