

The homeless and the emergency department: a special relationship

Why do some “frequent flyers” of the ED gain a permanent place in our hearts?

RECENTLY, the death of a homeless man who had lived in a bus shelter next to our inner-city emergency department (ED) for a quarter of a century made national and international headlines.^{1,2} Here, I present the story of this man’s relationship with the ED and also describe our involvement with two other homeless men. Then, I ponder why it is that patients like these can make such an impact on the health-care workers who come in contact with them.

Karl, the bus-stop man

Although Karl did not present as a patient every day, we saw him in the ED every day, as he used our waiting-room toilet as his own. We found him to be a very quiet, private, polite, kind and gentle man. The nuns and hospital staff (especially the nurses and social workers) would give him tea, biscuits and sandwiches when he visited, but rarely did he accept other offers, such as assistance in securing alternative accommodation.

He lived in a corner of a nearby bus shelter, and neither he nor the shelter could be considered pleasing to the discerning nose. We repeatedly tried to coax him into the ED for a clean-up and a new set of clothes. On the odd occasion he did accept the offer of a clean-up — notably on Christmas Eve in 1993, when the hospital notes document that the nurses handwashed his clothes when he wouldn’t part with them. He even allowed us to trim his beard a little, and we did think he looked rather like a Santa Claus. Perhaps it was because of his Christian background that Christmas was the only time he ever seemed to truly relax and enjoy being in the presence of the ED staff.

Perusal of Karl’s medical record reveals only seven official attendances, including three overnight admissions under my name. In spite of a past history of alcohol misuse, his health problems had been limited to chronic venous insufficiency, swollen legs, cellulitis and scabies infestation. During one admission, an ED registrar had asked jokingly, “Is it Karl’s birthday?” (in fact, we didn’t know his date of birth, and never did find out). On another occasion, during winter, I had admitted him overnight simply because the outside conditions were harsh and he was fearfully cold.

In September 2002, Karl was found dead, of natural causes, in his bus shelter. The outpouring of sympathy for this unassuming man, who had become such a “fixture” in the life of the ED, was amazing. Even in death, his life was an enigma. From what could be pieced together from the locals — people whose children he had helped to catch the bus, shop owners and waitresses from whom he had bought or had received gifts of coffee and food (including bacon sandwiches — his favourite), nuns who crossed the road near his bus shelter on the way to and from their convent (whom he uniquely acknowledged by accepting their gifts and offering a smile and ever-so-rare words), and the nurses whom he had looked out for in the dark as they returned

home after working a late shift — it became apparent that he had had a daily routine, a circuit. But he had never let us get to know him and never revealed anything about his history.

We felt he was a loner by choice and we respected that choice. Unlike other homeless people we saw in the ED, he was never seen to be intoxicated, rude or aggressive.

Karl was a man who spoke with his eyes rather than with words. When he died, many of us truly grieved for this kindly, silent, bearded figure.

Harry, the newspaper man

Another younger, homeless man evoked a similar feeling of loss upon his demise — this time, the death actually occurred in our ED. I have written of his case previously,³ partly because of its general medical relevance but also because I found myself, like many others in the ED, emotionally affected by it.

Harry was a scrawny, wiry man of 40-something who looked a great deal older than he actually was. We frequently saw him in the streets around the hospital. Any greeting of “Hullo” or “Good morning” that we gave him was returned with gusto.

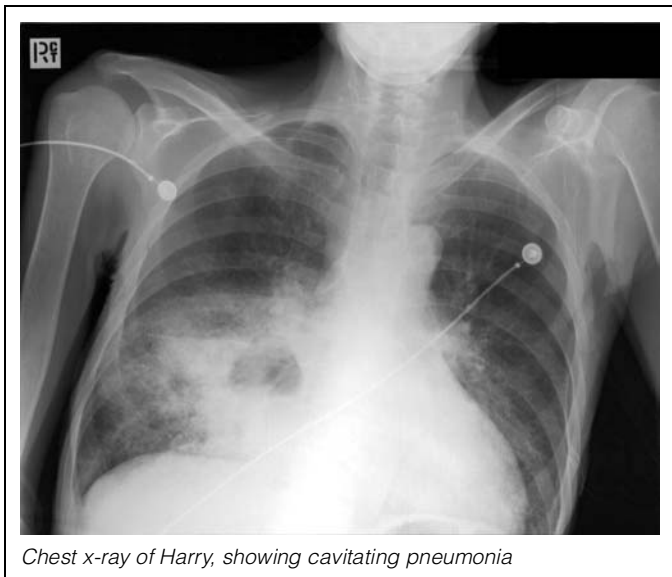
We knew him as the man who sold newspapers. We thought this was his way of earning a little more money, as we knew that he drank. He never talked about himself and never asked for a handout.

I remember clearly the morning he was brought into the ED by ambulance, having had a witnessed collapse. Quickly it became evident that he was critically ill — he had septic shock secondary to cavitating pneumonia (Box). However, once we had reversed his profound hypoglycaemia (0.7 mmol/L) and commenced to warm him up from his hypothermia (33.5°C), he just kept apologising to us for being a trouble.

Over the subsequent hours, we tried to save his life, and did successfully bring him through a broad complex tachycardia. All the ED staff, including non-healthcare staff, were focused in their concern for him, with everyone requesting frequent updates. Unfortunately, we lost him following an arrest. Although he put up an amazing fight, advanced resuscitation, including defibrillation, could not save him.

The ED staff went quiet in their grief. Many, including myself, shed a tear. We knew this patient and he had expressed his appreciation of our efforts — even as he was dying.

It turned out that he, like Karl, had been a loner. Before he died, he asked us to contact his only friend — the newsagent who supplied him with papers, basic accommodation and the sincere care that only a friend can provide. There were no relatives and there was no past we could piece together. His absence from the neighbourhood haunted us long after his death.



“John”, the “scratchie” man

“John”, a street person with drug use issues, is one of our most frequent attendees currently. He is highly intelligent, very manipulative, and almost totally non-compliant with antibiotic therapy for a septic knee and sundry other complaints. Even when coaxed to stay in the ED for treatment once difficult intravenous access has been established, he manages to escape several times a day on crutches or on one of our wheelchairs (generally by using the ruse that he is going out for a “smoke”). On one such outing, he bought a lottery “scratchie”, and on his return asked a nurse to check whether he had won anything. For a while there, we all thought he had scratched himself \$50 000; he was festively congratulated and we were all very happy for him. When it turned out that an unfortunate minor technicality meant that he just missed out on his prize, the ED staff immediately passed the hat among themselves so they could buy him another couple of scratchies.

Discussion

Many homeless and disadvantaged people use the ED as their main point of access to healthcare and social care.⁴⁻⁶ Outside normal working hours, calling in at an ED may be the only practical option available to them. The three cases described here illustrate the bond that can develop between ED staff and the homeless people who visit at irregular times.

ED staff will know which of their regular visitors are living “rough”, either by their address (“no fixed address”, multiple changing addresses, or homeless shelter address cited in the medical record), or by talking to other staff or the patients themselves.

Maybe it is because EDs are always available and the staff will, with each presentation, listen to the homeless person’s issues, talk to them and try to work out something for them, that there develops a caring bond between the homeless and ED staff.

Why do we care? I have mused often about this question and have asked my staff for their thoughts on the matter. The demanding work of an ED tends to attract staff with certain qualities in common. One is our need for gratification — we want to do things and see results, despite the difficulties. This is not necessarily an easy task — many (but not all) homeless patients are “hard work”. They may present to the ED in a confused or demented state; they may be anxious or plain scared. Some fight to reject any care offered to them; others, because of their personalities, mental-health and/or substance-use disorders,^{7,8} may be overtly rude, aggressive, and verbally and/or physically abusive to all around them. At times we get frustrated and upset, but over time we get to know each of their names and their individual needs. We are persistent, trying over and over again to help them. With each new presentation, both “sides” may begin their “games” anew.

Whether the homeless to us, or we to them, become familiar or even “family”, I think all ED staff, on the whole, feel privileged to be in a position to offer not only core healthcare but also comfort and help to homeless people. This is, I believe, why we are so sad and reflective when we lose one of them.

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