In medical school we learn by engaging with theoretical scenarios. We are given cases written by experts in the field and assured that they are emblematic of what we will see in practice. We work through complex ethical scenarios, and make predictions about how we will respond, how we should respond. Particularly this year, with COVID-19 restrictions, we are even further removed from the realities of practice, from the reality of people's lives. We practice physical exams, look for signs of illness on healthy bodies. I have never heard a heart murmur but could recite the characteristic sounds signifying pathology of each valve. I have never chosen between different treatment paths but know that we are meant to choose the one with the greatest benefit and the least risk of harm. Unsurprisingly, the theoretical and the practical knowledge do not perfectly align. Even what seems easy or obvious coming out of pre-clerkship: having compassion for your patients, building trust and rapport, teamwork, doing no harm – turn out to be skills that need to be crafted and honed. That do not come easily or obviously, but are skills that are built; values that are re-committed to every day. These lessons were particularly poignant when learned while working with a population who has been profoundly disenfranchised and subject to numerous harms at the hands of institutions like the medical system: people living with addictions. When a conscious decision is made to work against stereotypes, to treat people with respect and dignity, society is well-served.

From day one, we are told to be compassionate. What this means is never fully elucidated, so I will attempt to do so here. Compassion primarily comes from understanding. In addictions, this means understanding the vast and complex interaction of risk factors for addiction: genetics and family history, the impact of environment and learned behaviour, of trauma and abuse, mental illness, chronic disease, of low income, unstable lives, poor supports or a lack of stable housing. Often, people with addictions do not have just one of these factors, but multiple, interacting, accumulating. One physician I worked with described addiction as a "sociological illness", which points to just how strongly the environmental and social factors influence the process. Compounding recovery is that many of these influences remain. More to the point, addiction is still often seen as some kind of failure of moral character, a lack of willpower or a choice, as opposed to what it is: a complex biological, sociological, and societal illness. These values are codified into law as punishment for use or possession – no wonder the stigma and antagonism remain. It is easy, too, for this antagonism to creep into medical practice – to blame patients when they do not adhere to their treatment plan or continue to 'use'. It is immensely difficult to see these behaviours as symptoms of the disease, as was evidenced by one memorable phone call where the doctor described a patient selling prescribed medication to pay for cocaine as just that: a symptom of the disease. If not for the illness, they would not be engaging in that behaviour. It is not fair to label that patient "difficult" or "untrustworthy" – they are, quite simply, living with an addiction, and doing their best to manage it, as best they know how.

More difficult still is to have the same compassion for all kinds of patients. I vividly remember one patient who presented for Opioid Replacement Therapy (ORT). The nurses presented their impressions of her from the intake interview they had just completed, and you could tell by their tone that she had made a good one. She was well-liked already, despite it being her first appointment. Doctors and nurses are not ones to show much emotion, but the air in the room became palpably heavier as the nurses told the patient's story. First drink as a child. Problematic use in her teens. A list of substances, tried or abused. A father with schizophrenia who died by suicide. A mother with AUD. Sexual abuse. Suicide attempts. More family members who died by suicide, friends who died from overdose. Depression, anxiety, and withdrawal. When she entered the room, her hands were shaking. She spoke quietly, made

eye contact, smiled at me behind her mask. When she left, the doctor turned to me and told me how lucky she was. I was surprised, at the time, but what he meant was that her prognosis was good – despite her long and difficult history, she was young, she was beautiful, she was personable. The fact that she was easy to like meant that she was probably going to do well, and more than likely, have the supports she needs to recover.

Now imagine a different patient. One who presents to the emergency room inebriated, combative, yelling. Who speaks tangentially, as if he were purposefully going out of his way to not answer your questions. It is easy to label that patient 'uncooperative', or 'drug-seeking.' It is far more difficult to determine what help that patient actually needs. Such was the case with one patient in the adolescent psychiatry clinic. After dozens of presentations at the ED, inebriated and aggressive, dismissed as a cluster B personality type, he was finally referred to the clinic. And there, after an hour and a half-long interview, it was revealed that he had a severe intellectual disability. One that rendered him isolated, emotionally labile, and using medications to cope. When we take the time to understand, even if that understanding is simply that there are more factors at play than are immediately evident, compassion is born. And everyone is deserving of it.

Another lesson was trust. Once again, a particularly poignant lesson in the addictions population, where the default stance – in our criminal code, in our institutions, even by our parents – is one of antagonism and suspicion. I am thinking of a patient, once again, in the adolescent psychiatry clinic who had a substance use disorder. His mother asked what she could do to help him, offering up ways to monitor him, or punish him, as options. I will not forget the doctor's advice, in return: "Support him. For every one critique you offer, make sure to offer up five positives in return." After all, they are his decisions. It is his life. And when we see addiction as more than a disease of substance and use, but of disconnect and difficulty, this attitude makes perfect sense.

The effect that trust can have was beautifully evidenced one day in ORT. A patient came in, successfully stabilized on methadone maintenance, when the nurse walked in with a sticky note: "Cocaine +" it read. The patient had denied the use of any other drugs. Gently, gradually, the doctor began to talk about the risks of cocaine use during the treatment of an opioid use disorder. The patient, previously smiling and chatting, fell silent, and tears began to roll down her cheeks. It was hard, she said. She felt like she was just getting a handle on her opioid use, but the cocaine was still there. It would make things a lot easier, she said, if she could get caries, and not have to pick up her methadone every day. The risk was too great, the doctor offered, while she was still using cocaine, but if she came in next week with a clean urine, she could start on caries right away. The effect was immediate. Her eyes lit up, filled with hope. No lengthy trial period, no need to prove that she could stay clean without the resource she needed to stay clean. One clean urine – her needs could be met, and safely. This is what trust offers the patient: hope, and the knowledge that they are worthy of that trust. After all, that is what the urine screen is for: so that the doctor can know if their treatment is going to do more harm than good. It is not a lie detector. After all, as doctors and nurses have told me in turn: "Trust, but verify". At first, I thought this was contradictory. Now, I think I get it. We trust. And we verify. After all, is it worth it to be suspicious of everyone to catch the 1% that is lying to you?

Finally, a lesson so well-integrated into each practice that I nearly did not notice it, was the teamwork inherent to each practice. This teamwork was more than the practical, though it was that, too. There was an order that patients met with the team: with nurses at intake, or to perform screens, to manage

prescriptions. It was more than this separation of duties, though, that stood out to me, something that I have only been able to describe as “non-hierarchical”. There was an implicit acknowledgment, every time a team member interacted with one another, that neither was above the other. The doctor was not more valuable than the nurse, nor even more valuable than the lowly med student. I felt this acutely the very first time I walked into the pain and addictions clinic, when the doctor offered to get me a coffee. Then again, when he looked me in the eye, or walked beside me, instead of in front of me, or asked me a question, and took the time to listen to my thoughts. These small acts granted me a dignity, and acknowledgment, that I will not soon forget. Every time I came in, I was made to feel like a member of the team. I am sure that the patient notices this too, or at the very least would notice the lack thereof. The patient, too, is part of the team. Their needs were listened to, acknowledged, and incorporated into the plan. If their pain is not controlled, if they need more medication, even if they have a preference – a change is made, as long as it is safe to do so. This is harm reduction. This is dignity. As one doctor so eloquently put it, “the opposite of addiction is connection,” and I think that connection starts with ourselves. With how we treat our patients, yes, and with how we treat each other. As one patient proclaimed: “When you lose touch – that’s when it gets you. You think you’ve licked it, but you never lick it.”