

# Virtual Mentor

American Medical Association Journal of Ethics  
January 2009, Volume 11, Number 1: 61-71.

## MEDICINE AND SOCIETY

### The “Army of Lost Souls”

David A. Iverson, MD, Marilyn Cornell, MS, MFT, and Paul Smits, MSW

*Editor’s note:*

*Homelessness and untreated health problems among U.S. veterans cause much public unease and, frankly, some embarrassment. Why can't society take proper care of those who risked their lives in our name? Virtual Mentor asked three authors who work with Veterans Administration programs and homeless veterans to explore that question.*

### Our Duty to Homeless Veterans

David A. Iverson, MD

My pager went off at one o’clock in the morning. I called the number—a group home—and the manager declared urgently, but simply, “They shot Jack. Can you come?” By the time I arrived, the coroner had left with the body. Jack was a homeless veteran with serious mental illness and alcoholism. On this cold night, he had been drunk, and, when told that he’d have to leave the shelter, he had no intention of complying. After Jack brandished a knife the manager judiciously backed away. Thinking the dispute was settled, Jack climbed into one of the beds, not knowing that 9-1-1 had been dialed. When a police officer entered Jack’s room, Jack charged him, knife in hand. The officer didn’t hesitate; he fired six bullets into Jack’s chest, killing him.

Miraculously, only a few of the other residents were awakened. One was Jack’s roommate, also a homeless veteran, who, pressed into the corner of the room, watched the bullets fly by. Still shaking, he said, “There was no way Jack was going out into that cold. Not again. Not tonight. He went out like a soldier.”

We had a decision to make before morning: call a hazmat team to clean up the blood (this would cost thousands), or clean it up ourselves. Having worked with Jack for years, it seemed important that we do it, perhaps as a way of honoring him. At 4 a.m., with bleach in hand, I opened the window, turned Jack’s bedside radio on low, and in the cool, quiet morning cleaned up his blood and gathered his few personal belongings for his family.

The work I did with Jack did not occur within the Veterans Administration (VA) but at a local homeless clinic. Tragedies like this one, despite the challenge of enduring them, bind us to our homeless patients and their plight, which continuously

recommits us to the work. Not coincidentally, I work for the VA now, and do so with pride.

The public is turning its attention to homeless veterans, partly in response to the Iraq War. Our country makes a promise to those who serve in our Armed Services—a promise derived from the words of Abraham Lincoln’s second inaugural address, “To care for him who shall have borne the battle, and for his widow, and his orphan.” Soldiers are the only group of citizens in our society to whom we promise health care for a lifetime. While we simultaneously fight two wars, the public is justified in wanting to know why a vet with serious mental illness must seek shelter in a group home or why a homeless man on a street corner holds a sign reading, “Homeless Vet—Please Help.”

The statistics are impressive and sobering. Veterans are over-represented among the homeless, at approximately one in four, whereas one in 11 Americans is a veteran [1]. The reasons are not yet clear, but that doesn’t stop us from asking, “What is the VA doing about it?” For starters, the VA operates the largest health care system in the world, serving a sizable segment of our population. Of the nation’s 26 million veterans, nearly three-quarters served during a war or official period of conflict. Approximately one-quarter of the country’s population is eligible for VA benefits and services because they are veterans, veterans’ family members, or survivors of a deceased veteran.

The VA operates 1,400 sites of care, including 155 medical centers, and VA services designed specifically for homeless veterans are growing. The Healthcare for Homeless Veterans program helps veterans get off the streets and provides them support services. Compensated work therapy supplies structured, supervised work. Assertive community treatment, peer assistance, and an array of substance-abuse services—outpatient to residential—are also available through a nationwide network of programs. The VA operates numerous “domiciliaries” that offer longer-term housing and skills training to help formerly homeless veterans make a successful transition to independent living. The overall success of the VA’s national network of care is outlined in *Best Care Anywhere* [2].

But the VA also represents arguably the second largest bureaucracy in the world (the Department of Defense being first). And, despite the fact that bureaucracies are designed to handle large numbers of people fairly, they are not known for being flexible or maneuverable, which can hamper efforts to meet homeless people where they are. Individuals sometimes become lost in the bureaucracy and do not receive the care intended for them. By way of emphasizing challenges such as this, consider these numbers: in Colorado we manage more than 400 vouchers that secure shelter, protection, and nightly services to homeless veterans—a commendable accomplishment. But the vouchers serve a fraction of the estimated 2,500 homeless veterans in our state. As VA physicians and staff, we want to be able to do much, much more.

Any physician who has cared for homeless people knows that their difficulties are often complicated and entrenched. It is important to recognize that homelessness is really only a partial descriptor—such a person is often jobless, undereducated, without family support, poor, and alone. Indigence—meaning the lack of health insurance—is a problem for the field of medicine to address; homelessness itself is a problem for society as a whole [3]. As physicians, it is important that we seek answers to why the problem persists.

In its list of nine principles, the *AMA Code of Medical Ethics* compels us to practice with compassion, to respect human dignity, honor the law, and accept responsibility for improving our communities [4]. Working with homeless people can sometimes make physicians doubt whether they are practicing ethically. I believe the contributors to this doubt are the powerlessness and confusion we feel when faced with overwhelming need. Not knowing what actions to take should never be confused with not knowing the *right* actions to take. Ethically, the choices we must make in providing care for a homeless veteran (or any person who is homeless) are relatively clear—such as whether a homeless person should be admitted to the hospital. Should that admission be involuntary? Does the person need a guardian? Should the family be sought out? Can we devote the time right now for this person's obvious needs? I believe the answers to these questions hinge upon whether our health care system and society as a whole—not just the VA—is ready and willing to provide the full support necessary to create lasting solutions to these complicated issues. Homelessness is seldom cured with one hospitalization. So much more is required.

In his remarkable book, *War and the Soul: Healing Our Nation's Veterans from Post-traumatic Stress Disorder*, Ed Tick reflects upon 30 years of counseling war veterans [5]. His experience has led him to conclude that posttraumatic stress disorder (PTSD) is not an anxiety disorder, as classified in the DSM IV. Instead, it is the expression of indelible change to one's self and one's soul as a direct result of experiencing war—and a reflection of our culture's failure to honor, accept, and “cleanse” our warriors. Veterans on the streets, possibly thousands of them with PTSD, may represent a literal army of lost souls.

Underscoring the complexity of the problem is a 2004 finding by Mares and Rosenheck that fewer than one-third of homeless veterans identified their military service as the cause of their homelessness [6]. Their article also stated that the average lag time between discharge from the military and the first episode of homelessness was a lengthy 14 years. Veterans who did attribute their homelessness to their military service cited the reasons as being (1) a substance-abuse problem that began during the military, 75 percent; (2) inadequate preparation for civilian employment, 68 percent; and (3) loss of a structured lifestyle, 60 percent. Few of these causes can be interpreted as directly related to military life. We can question, then, whether veterans as a group share risk factors for homelessness beyond combat trauma alone.

Could we have spared Jack his violent death? It's impossible to know for certain. We do know that alcoholism and chronic mental illness cause too many premature deaths and that treatment works when it is made readily available for those who want it. Our goal is to keep striving to help others like Jack. Otherwise, for what purpose are we here? The VA strives to accomplish more each day. Together, we must advocate for a comprehensive public and private health care system that promises care not only to veterans, but for all.

### References

1. Schram M. *Vets Under Siege*. New York, NY: St. Martin Press; 2008.
2. Longman P. *Best Care Anywhere, Why VA Health Care Is Better Than Yours*. Sausalito, CA: PoliPointPress; 2007.
3. Baum AS, Burnes DW. *A Nation in Denial, The Truth about Homelessness*. Boulder, CO: Westview Press; 1993.
4. American Medical Association. Principles of medical ethics. 2001. <http://www.ama-assn.org/ama/pub/category/2512.html>. Accessed December 4, 2008.
5. Tick E. *War and the Soul: Healing Our Nation's Veterans from Post-traumatic Stress Disorder*. Wheaton, IL: Quest Books; 2005.
6. Mares AS, Rosenheck RA. Perceived relationship between military service and homelessness among homeless veterans with mental illness. *J Nerv Ment Dis*. 2004;192(10):715-719.

David A. Iverson, MD, is a psychiatrist and director of the outpatient mental health services for the Denver VA Medical Center and the Eastern Colorado Health Care System. His interests are veterans affairs, homelessness, mental health law, forensics, and ethics.

### Community Response to the Health Care Issues of Homeless Veterans

Marilyn Cornell, MS, MFT

The homeless veteran population persists for many of the same reasons that the homeless nonveteran population does. Some are “situationally homeless” as a result of economic hardship, such as loss of employment or a change in life circumstances—like divorce, death of family members, or domestic violence. Others suffer from untreated mental illnesses, including psychotic disorders, mood disorders, or posttraumatic stress disorder. A significant number of homeless people bear drug and alcohol addiction or failure to integrate into society following military service, incarceration, or long-term hospitalization. Few choose a life of nomadic isolation as a “career track,” but they become accommodated to living on the fringe of society in a self-imposed form of social isolation that prompts many to become numb and resigned to their situation. It takes a Herculean effort to mobilize the internal and external resources, energy, and motivation to move oneself from homelessness to stability without outside assistance. As a result, many remain homeless for months or years, often establishing a pattern of episodic homelessness that repeats throughout their lifetime.

The health consequences of living on the street are dire. Homeless individuals are more likely to contract serious infectious diseases such as tuberculosis, pneumonia, or *methicillin-resistant staphylococcus aureus* (MRSA). Long-term drug use places addicts, especially intravenous drug users, at risk for contracting HIV and hepatitis. Another hallmark of chronic or episodic homelessness is lack of dental care. Many veterans suffer from missing or diseased teeth or gum conditions and are unable to chew. Their food options, already restricted by economic hardship, become very limited. As a result, many are malnourished, in pain, and often need antibiotic treatment.

Many community groups have been founded to offer needed services to homeless veterans. Veterans Village of San Diego (VVSD), a residential treatment facility for homeless veterans with substance abuse habits, is one. It provides housing, food, access to medical and dental care, alcohol and drug education, recovery meetings, case management, mental health counseling, employment services (job training and placement), and non-traditional options such as expressive-arts therapy, yoga, acupuncture, and massage.

VVSD was founded in 1981 by five Vietnam veterans who were struggling with PTSD and readjustment after their combat experience. They established the program with a \$10,000 grant from the San Diego mayor's office to help find jobs for Vietnam veterans. Their first 44-bed residential treatment center, The Landing Zone, opened in 1984 with the motto, "We leave no veteran behind." Today the Pacific Highway facility is a 224-bed treatment center, licensed by the state of California for alcohol and drug treatment. Sixty to 70 percent of VVSD's patient population is "co-occurring," that is, diagnosed with both a substance abuse and a mental health disorder.

In 1988, Stand Down was created by several Vietnam veterans, including Robert Van Keuren, who was executive director of Vietnam Veterans of San Diego, and Jon Nachison, PhD, a psychologist. They sought to address the growing number of homeless veterans in San Diego. For 3 days each summer, billeting tents and service providers congregates for the benefit of homeless veterans and their families from the streets. The local VA Medical Center at La Jolla erects a field hospital to offer a broad range of medical treatment, including alcohol and drug detox, tuberculin skin tests, HIV testing, dental care, optometry, podiatry, psychiatry, pharmacy, and to triage care for other conditions regardless of the participant's eligibility for VA medical benefits. (Veterans who received either a dishonorable or bad conduct discharge from the military or did not serve the requisite number of days or months on active duty are not eligible for benefits.)

In July 2008, 830 participants at Stand Down received care. VVSD typically brings in at least 15 eligible participants from each year's Stand Down as residents of its long-term treatment program [1]. The average VVSD population is 140 male and

female residents, a total that will increase to accommodate the rising number of veterans in need.

Upon entry to VVSD, each resident is given a brief medical exam by a physician who screens for problems that need referral and immediate attention. Approximately 85 percent are eligible for VA medical benefits and services and get care from several locations including the VA Medical Center in La Jolla and the VA Regional Office in Mission Valley. Those who do not qualify for VA medical benefits are seen by the mobile medical van which visits VVSD twice a week. The local VA also has several social workers who act as liaisons to VVSD and coordinate medical and psychiatric care. They perform intake interviews with all residents to determine their eligibility for per-diem funding and attend weekly clinical treatment meetings to assist in removing barriers to medical and behavioral care. They also review treatment records and bring staff up-to-date treatment information from the VA if the veteran has signed the appropriate releases.

A health care case manager coordinates all non-VA care through family health centers. Residents who are registered with the California Department of Corrections and Rehabilitation and on parole have access to mental health services and obtain their psychotropic medications through the parolee outpatient clinic.

Veterans can stay in the treatment facility for up to 1 year, with 30-day extensions on a case-by-case basis. They may then live in a transitional sober-living site for an additional 2 years. The 14-bed Mahedy House is for working vets who need a sober environment, and the 44-bed New Resolve Program in North County houses residents who are employed or attending school. The Welcome Home Family program is a 2-year transitional-living program for veterans and their families. Residents in all these programs are offered ongoing mental health treatment to assist them with chronic mental health concerns and readjustment to daily living.

In a perfect world, VVSD would incorporate both a detox center and a full medical clinic as on-site services, but funding remains a challenge for all nonprofit agencies. VVSD receives grants and contributions from federal, state, and local sources, in addition to public donations. The current economic forecast, however, means all organizations like VVSD will have to continue to find creative ways to meet the health care needs and challenges of this population.

The global war on terror, and the conflicts in Iraq and Afghanistan specifically, challenge our ability to meet the medical and psychological needs of our returning military. Recent Rand Corporation research estimated that 300,000 returning military suffer from PTSD, another 300,000 suffer from traumatic brain injury (TBI), and another 100,000 overlap both categories. These numbers will certainly tax the VA and community treatment networks. It is believed that it took Vietnam veterans approximately 10 years to fall through various safety nets of family and community before landing on the streets as homeless veterans. Based on the number of younger

combat veterans who are already homeless, we anticipate that the current generation will end up on the streets in half that time.

In fact, some of these young combat veterans are being treated in VVSD. To date, 20 have been served at various sites. Americans now seem to have more respect for the military, have learned the lessons of Vietnam, and are willing to “hate the war, but not the warrior.” Whether or not this translates into funding for medical and mental health treatment remains to be seen. The United States prepared for the war, but not for the returning veterans. Their future health care needs are robust, and it is doubtful they can be properly met. In 3 to 5 years, VVSD projects that 75 percent of its population will be Iraq and Afghanistan combat veterans. As of January 2009, VVSD implemented a new program to meet the specific needs of these veterans, including health, wellness, and other classes specifically for this population.

As part of their intake questionnaire, new physicians and medical students should ask the homeless, “Did you ever serve in the military?” Many veterans do not trust the Veterans Health Administration based upon residual myths and beliefs left over from the Vietnam era. Also, more women are now serving in the military, and many have seen combat, but they traditionally do not access veteran’s benefits and do not identify themselves as veterans. Treating all veterans with respect, thanking them for their service, and allowing them to tell their stories will help educate caregivers as to the most appropriate level of care.

Marilyn Cornell, MS, MFT, is a clinical director for Veterans Village of San Diego and serves as adjunct faculty at San Diego State University, teaching courses in counseling and psychology. She has been a licensed marriage and family therapist for nearly 20 years, providing outpatient treatment to veterans and their families. She has also been a volunteer at Stand Down in San Diego for 20 years and serves as the organization’s tent leader coordinator.

### **Reference**

1. Veterans Village of San Diego. Stand down. 2008.  
<http://www.vvsd.net/standdown.htm>. Accessed December 3, 2008.

### **Veterans’ Recovery for the Homeless**

Paul Smits, MSW

The issue of homelessness troubles many Americans, particularly when it involves individuals who have made selfless personal sacrifices for our country—U.S. veterans. Although the numbers of homeless veterans have decreased steadily over the last 10 years, it is estimated that there were 154,000 homeless veterans on any night in the United States in 2007 [1]. The decline notwithstanding, the presence of one homeless veteran is unquestionably too many.

A common misperception about homelessness is that it is caused by poverty, lack of affordable housing, or unemployment. Those who have fought to end homelessness

know these factors are only part of the story. A majority of homeless people have health conditions that interfere with their ability to become productive citizens. Health care agencies report that homeless patients have high incidences of respiratory infections, trauma, skin ailments, gastrointestinal ailments, and hypertension. Dental problems are common, as are communicable diseases such as HIV and tuberculosis, with HIV being three times as prevalent as in the general population [2, 3]. Most noteworthy is that substance abuse and mental illness are widespread and play a significant role in contributing to chronic homelessness. These contributors are not specific to veteran homeless; nonveteran homeless people suffer from similar health conditions.

The Department of Veterans Affairs (VA) has provided services to homeless veterans for 21 years, during which time it has collected extensive data on homeless veterans through VA's Northeast Program Evaluation Center (NEPEC). NEPEC has been actively involved in the design, implementation, and evaluation of VA's specialized programs for homeless veterans from their beginning. Fifty-eight percent of homeless veterans report health problems. Even more striking is the fact that 66 percent carry diagnoses of alcohol or drug abuse and 51 percent have serious psychiatric diagnoses. Thirty-seven percent have both a substance-abuse diagnosis and serious psychiatric diagnosis [4]. Clearly, this data confirms that health care must play a critical role in addressing homelessness and achieving lasting results in ending it.

The VA programs have been built on the recognition that health care plays a critical role in rehabilitation of homeless veterans. The Veterans Health Administration has more than 330 staff members who reach out to 40,000-plus new veterans annually and offer services to 65,000 veterans through its specialized programs [4]. A detailed assessment of each veteran is conducted almost immediately and produces a comprehensive package of rehabilitative services designed to meet that veteran's housing needs; medical, psychiatric, dental, and substance-abuse treatment needs; case management; vocational and employment needs; and, in many cases, assistance with obtaining benefits for disabilities.

Although the VA is uniquely positioned to provide many of these services, its strategy has been to deliver them in collaboration with nonprofit community and faith-based organizations, state programs, other federal agencies, and Indian tribal governments. These collaborations are critical to meet the complex needs of the homeless veteran and his or her family. Providing one or two services to a homeless person in hopes that it will lift him or her out of homelessness is not realistic and sometimes contributes to yet another failure on the part of the individual to end his or her homelessness. At present, the VA's Homeless Providers Grant and Per Diem Program offers transitional housing with supportive services through 330 community-based programs, with almost 9,000 beds currently available that grant rehabilitative care to more than 15,000 veterans per year [4]. In 2008, the VA initiated a 10,500-unit expansion of the Housing and Urban Development-VA Supportive Housing (HUD-VASH) permanent housing program. Through the

endeavor, permanent community housing, subsidized through HUD-housing vouchers and managed by local public housing authorities, is paired with clinical VA staff case-management services.

Health issues prevalent in this population can significantly interfere with the veteran's ability to fully utilize other support services. To ensure that veterans receive these health care services, the Veterans Health Administration has initiated three national performance monitors which measure whether homeless veterans have timely access to primary care, mental health care, and substance-abuse treatment. A fourth monitor measures VA's performance of guaranteeing continuity of care for veterans who depart from those specialized programs.

Many homeless veterans receive care through outreach activities in which social workers and other health care professionals bring services to street missions and other places where homeless people congregate. But homeless veterans also come directly to VA's health care facilities and meet with professionals who are knowledgeable and trained to connect them with services. The VA recently issued a mental health handbook that describes a uniform mental health services package and requirements for care. If a veteran and his or her family come to a VA clinic or hospital, the veteran must be given access to a variety of options that include emergency shelter, placement in a residential treatment setting, and transitional or permanent housing with supportive services in addition to medical, psychiatric, or substance-abuse care.

Deferring care or sending a veteran back to the street is considered unacceptable by the Veterans Health Administration, which has adopted standards that spell out the requirement that services must be made available. All health care professionals and organizations should adopt standards of care that follow the VA's model. Recent instances of health care organizations dumping sick, homeless people on the street in skid row areas are deplorable.

In 2008, 21,000 homeless veterans received rehabilitative care services in VA residential programs [4]. More than \$334 million was spent on these specialized programs, and almost \$2 billion was spent in overall health care costs for homeless veterans [5]. It is the least that can be done for those who made great sacrifices for our nation.

At this point, the question must be asked, "Does the VA's strategy for delivering comprehensive care via collaborative relationships succeed?" The experience of the VA and its partners is that this approach has produced results—many formerly homeless veterans have been able to end their homelessness. The VA has conducted at least eight studies and followed more than 3,000 veterans for up to 3 years after entry in the VA program in a series of systematic program evaluations. All of these studies showed positive results, consistently estimating that 80 percent of veterans who entered the programs remained housed 1 year after entry, with even higher percentages of housing for those who successfully completed the programs [6-13].

The complexity of the problems of the homeless calls for a comprehensive, coordinated approach that can best be accomplished through partnerships between private and public agencies. Health care services are a critical component of a homeless individual's recovery—the reason the VA has taken a leadership role in coordinating health care and other services for U.S. veterans. With high levels of performance accountability, the efforts have shown results as good as those of any other program. The standard of providing homeless care delineated in VA's mental health uniform-services package is a model that can be emulated by other health care organizations. For the VA, the debt owed to our nation's veterans calls for no less.

## References

1. Kuhn J. CHALENG community homelessness assessment, local education and networking groups. 2008.  
<http://www.nchv.org/docs/MH%20Conf%207-08.ppt>. Accessed November 13, 2008.
2. McMurray-Avila M. *Organizing Health Services for Homeless People*. Nashville, TN: National Health Care for Homeless Council, Inc; 1997.
3. Allen DM, Lehman JS, Green TA, Lindegren ML, Onorato IM, Forrester W. HIV infection among homeless adults and runaway youth, United States, 1989-1992. Field Services Branch. *AIDS*. 1994;8(11):1593-1598.
4. Kaspro WJ, Rosenheck RA, DiLella D, Cavallaro L, Harelik N. *Health Care for Homeless Veterans Programs*. West Haven, CT: Northeast Program Evaluation Center; 2008.
5. U.S. Department of Veterans Affairs. FY2009 budget submission medical programs and information technology programs, Vol. 2 of 4.
6. Cheng AL, Lin H, Kaspro W, Rosenheck RA. Impact of supported housing on clinical outcomes: analysis of a randomized trial using multiple imputation technique. *J Nerv Ment Dis*. 2007;195(1):83-88.
7. Rosenheck RA, Frisman L, Gallup PG. Effectiveness and cost of specific treatment elements in a program for homeless mentally ill veterans. *Psychiatr Serv*. 1995;46(11):1131-1139.
8. Leda C, Rosenheck RA. Mental health status and community adjustment after treatment in a residential treatment program for homeless veterans. *Am J Psychiatry*. 1992;149(9):1219-1224.
9. Rosenheck RA, Dausey DJ, Frisman L, Kaspro W. Outcomes after initial receipt of social security benefits among homeless veterans with mental illness. *Psychiatr Serv*. 2000;51(12):1549-1554.
10. Rosenheck RA, Kaspro W, Frisman LK, Liu-Mares W. Cost-effectiveness of supported housing for homeless persons with mental illness. *Arch Gen Psychiatry*. 2003;60(9):940-951.
11. Rosenheck RA, Mares AS. Implementation of supported employment for homeless veterans with psychiatric or addiction disorders: two-year outcomes. *Psychiatr Serv*. 2007;58(3):325-333.

12. KasproW W, Rosenheck RA. Outcomes of critical time intervention case management of homeless veterans after psychiatric hospitalization. *Psychiatr Serv.* 2007;58(7):929-935.
13. Desai RA, Harpaz-Rotem I, Najavits LM, Rosenheck RA. Impact of the seeking safety program on clinical outcomes among homeless female veterans with psychiatric disorders. *Psychiatr Serv.* 2008;59(9):996-1003.

Paul Smits, MSW, is associate chief consultant, Homeless and Residential Treatment Programs in the VA central office in Washington, D.C. He manages the day-to-day operations of the Veterans Health Administration's (VHA) Grant and Per Diem Program, the HUD-VA Supported Housing Program, the Domiciliary Care for Homeless Veterans Program, the Healthcare for Re-entry Program (prison outreach), and VHA's homeless outreach services. He has a master of social work degree from Western Michigan University, is a veteran of the Vietnam War, and was awarded the Bronze Star in 1970. Throughout his 36-year career in the Department of Veterans Affairs, Mr. Smits has been involved in the development of the VA's homeless program. In 2003, he was awarded the prestigious Olin Teague Award for achieving outstanding results in the rehabilitation of homeless veterans.

#### **Related in VM**

[Boston HealthCare for the Homeless Program: A Success Story](#), January 2009

[Outpatient Commitment: A Treatment Tool for the Mentally Ill?](#) January 2009

[Hospital Resources: A Practical Treatment Plan for Homeless Patients](#), January 2009

*The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

Copyright 2009 American Medical Association. All rights reserved.