

Virtual Mentor
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FROM THE EDITOR

Healing in an Age of Homelessness

Samuel never had a life of comfort. When I began working at Christ House, a medical shelter for the homeless of Washington D.C., Samuel had been living there for more than a month. He had terminal throat and tongue cancer [1]. As a nursing assistant, one of my duties was to help Samuel organize his cubby and bed, which included discarding countless coffee cups, packets of sugar, and tissues containing phlegm and blood. While Samuel couldn't speak, we communicated using scribbled notes and sign language unrecognized by anyone but the two of us. He was a man who struggled with an incurable disease and a society that did not readily accept his acerbic personality and often hostile disposition. Yet, it was clear that the nurses and doctors who treated him understood his vulnerability and cared for him—giving him pain medicine, tolerating his antics, and smiling when tears welled in his eyes after he was given a scarf and gloves for Christmas. Samuel died at 58 years of age on a January morning after being transferred to Joseph's House, a local hospice for homeless men [2]. The story of Samuel's life highlights a question that I have long struggled to answer—how can medical professionals best serve the homeless, a community which in my opinion, has been historically neglected.

Following de-institutionalization of many mental health institutions in the 1980s, homeless men and women who were mentally ill were discharged to the streets with limited financial resources and social connections. At the same time, social services working with low-income communities were already burdened with high case loads and put together a patchwork of programs that never adequately met the needs of this newly homeless population. Welfare reform under the Clinton Administration and a Republican congress led to even fewer resources for low-income individuals. The current financial recession—with more than 10.3 million unemployed nationwide, 30 million receiving food stamps, and one in every 488 houses being foreclosed nationally—has blindsided many moderate- to low-income families and left them at risk of losing both their livelihoods and homes [3, 4]. The threat of homelessness may be frighteningly real to more people in these uncertain financial times. The articles in this issue examine themes that will always challenge our understanding of and compassion for those at the margins of society.

It is difficult to estimate the number of homeless people in the United States; between 2.3 and 3.5 million individuals, 1.35 million of them children, are likely to experience homelessness in a given year [5]. A 2007 study found that, among the *sheltered* homeless, 25 percent were disabled and nearly 20 percent were veterans. While most of the homeless were single adults, it is notable that more than 22 percent were under 18 years of age [6]. The homeless are more likely than the

general population to be diagnosed with obstructive lung disease, hepatic diseases, skin and orthopedic problems, and infectious diseases including tuberculosis and HIV [7, 8]. It is not surprising that this population is more inclined to suffer from chronic physical and mental illnesses than the general population and have shortened life spans associated with the lack of adequate housing and nourishment.

Despite declines in many social services otherwise available to homeless men and women, a number of physicians have stepped up to provide health care. Whether working in the emergency room, establishing respite care facilities and hospices, or teaming up with social workers in an outpatient clinic, physicians and medical students alike are learning the challenges that their homeless patients face on a daily basis. Serving as a healer requires more than simply treating the medical symptoms of a patient whose economic situation is more precarious than one's own. It demands an understanding and appreciation of the full needs of patients whose illnesses are complicated by layers of family fragmentation, social disengagement, and loss. A disease that one might consider manageable, such as diabetes, is complicated by the fact that shelters may not allow clients to bring in needles and may not have proper storage facilities for insulin. HIV patients required to take several medicines to combat their illness may struggle to do so when they don't know where they will sleep any given night. As a result, some go to emergency rooms or crowded outpatient clinics for primary care.

The cases, commentaries, and personal accounts in this issue of *Virtual Mentor* address patient autonomy, beneficence, and physician responsibility. Contributors include physicians, educators, public health officials, as well as graduate and law students. Each author describes his or her unique perspective on the issues that physicians face, whether debating the role a physician has in caring for a homeless mother and her child, talking with a patient who is malingering in the emergency room, or contemplating whether a schizophrenic patient should be reported for lack of compliance to an outpatient treatment program. Authors also discuss the singular needs of homeless veterans, the treatment decisions of homeless patients, academic programs that introduce medical students to providing care for homeless patients, and the treatment of homeless individuals who volunteer as research subjects. Personal accounts among seasoned advocates focus on those who are chronically homeless and those who have become homeless as a result of a natural disaster.

Together, the articles describe the current ethical challenges that both patients and physicians face and offer solutions that balance providing care for homeless patients with financial and social consequences of doing so. This month's authors share a passionate concern for the homeless community; I am grateful for their insight and guidance.

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Dedication

This issue is dedicated to the patients of Christ House and to the staff who care for them, particularly Susan Rieth, Mary Jordan, Brigid O'Connor, John McCarthy, and Jane Vroon, and to my parents, Nicholas and Kathleen Patchan, whose compassionate spirit has always been my inspiration.

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CLINICAL CASE

Outpatient Commitment: A Treatment Tool for the Mentally Ill?

Commentary by Scott C. Fears, MD, PhD, and Ann Hackman, MD

Dr. Jacobson, a psychiatrist working at an outpatient clinic in Cleveland, was waiting for his next patient, Mr. Miller, an Army veteran who had been living in a homeless shelter. Mr. Miller had been diagnosed with paranoid schizophrenia 10 years earlier following sporadic hallucinations and delusions that alienated him from friends and family. He had tried to cope with his illness by smoking marijuana and, for a time, became addicted to cocaine. On several occasions, he had become verbally assaultive and threatened strangers, prompting brief periods of incarceration. As part of his court-ordered release, Mr. Miller was required to participate in “outpatient commitment”—an arrangement that required him to attend weekly therapy sessions and self-help groups and submit to a supervised medication regimen.

Twenty minutes passed before Mr. Miller arrived at his therapy session and blamed the clinic office staff for his delay. Dr. Jacobson was weary of the excuse; Mr. Miller had used it before, and it had always turned out to be false. Furthermore, Dr. Jacobson sensed that Mr. Miller had become more anxious and irritated during sessions, but he was not sure why. Outpatient commitment had worked for Mr. Miller for several months, but Dr. Jacobson was uncertain about the best way to handle Mr. Miller’s change in behavior. If he reported Mr. Miller’s behavior, he jeopardized their therapeutic relationship. Nevertheless, Mr. Miller’s noncompliance was harmful to himself and possibly others. Dr. Jacobson asked himself whether his decision making would differ if Mr. Miller were not homeless.

Commentary 1

by Scott C. Fears, MD

In an ideal world, no patient would be coerced into treatment. It may be even more important to strive for this ideal in the field of psychiatry where self-motivation is a necessary prerequisite for meaningful change. There are cases, however, in which a physician must intervene despite a patient’s opposition. Traditionally, psychiatrists have used involuntary inpatient commitment as an intervention to address acute, life-threatening situations. More recently, outpatient-commitment laws have been developed as interventions for less-acute situations. These laws were initially proposed in the late 1980s to manage “revolving-door” patients who received periodic inpatient treatment but often relapsed because they did not become engaged in outpatient maintenance.

Outpatient-commitment laws were later expanded in part because of societal fears that individuals with mental illness were violent and uncontrollable. Kendra's Law in New York and Laura's Law in California are examples of legislation influenced by murders committed by mentally ill patients who refused or avoided treatment. In contrast to these motivations, families have advocated for outpatient commitment out of concern for the safety and quality of life of their mentally ill relatives who reject treatment because of their psychiatric symptoms. For physicians, outpatient commitment raises the complicated issue of paternalism and potential conflicts between societal and patient interests. In this commentary I argue that, despite the potential problems associated with outpatient commitment, it is an intervention that, when used with compassion and respect for the patient's dignity, can greatly improve his or her quality of life.

Establishing a Patient-Physician Relationship

Mr. Miller is a patient with whom it is difficult to establish a therapeutic relationship. He has significant paranoia, thought disorder, and impaired judgment. Furthermore, his experience with the legal system has most likely left him with an aversion for institutional authority figures, including, in this case, Dr. Jacobson. Therefore, Dr. Jacobson is in a double predicament; Mr. Miller is unlikely to engage in voluntary treatment, and the coercive nature of outpatient commitment is a major barrier to establishing a therapeutic relationship. Specifically, coercive treatment is likely to aggravate Mr. Miller's paranoia and inhibit the development of a trusting therapeutic bond. Dr. Jacobson must work to make the empathic nature of the relationship apparent, while unambiguously communicating the requirements of the situation.

The situation can create inner tension in Mr. Miller; he will have to accept Dr. Jacobson as both an authoritarian representative of the court (which will lead to anxiety) and an empathic healer who is trying to provide help (which will lead to hope). In nonpsychotic patients with better coping skills than Mr. Miller's, similar feelings of ambivalence often result in treatment noncompliance (lateness for therapy appointments, skipping medications, etc.). It is unreasonable to expect a psychotic patient to be able to follow a regular treatment schedule without exception. Furthermore, Mr. Miller's recent behavior is not surprising and may represent a normal phase of treatment.

Motivating Treatment

Unfortunately, Mr. Miller is at high risk for discontinuing treatment, and it is essential that Dr. Jacobson address two issues. First, he must determine why Mr. Miller is becoming more irritable and anxious. It could be a symptom of worsening depression or psychosis or a relapse to cocaine use—conditions that might require medication changes. As alluded to above, however, these symptoms might also be a consequence of Mr. Miller's struggle to establish trusting relationships with his therapist and self-help groups. Dr. Jacobson's second important task, then, is to convince Mr. Miller that, regardless of the underlying cause of his increased anxiety, the possible consequences of his behavior are severe. If he is brought before the court he risks a return to jail. Here, the court can be used as a third-person authority

to substitute for the patient's impaired ability to make good decisions. For example, Dr. Jacobson may frame the treatment goal as, "How do we keep you out of jail?" The approach establishes an alliance with Mr. Miller by providing a concrete goal to motivate treatment. It also has the advantage of focusing on an element of reality that both the doctor and patient agree is important. Mr. Miller may not agree that stable housing, reduction of psychotic symptoms, or decreased cocaine use are important goals, but he is likely to be motivated by avoiding incarceration.

Improving Compliance

Dr. Jacobson must decide whether to report Mr. Miller's recent behavior to the court. In my opinion, he should not report him at this point. In the absence of dangerous behavior, treatment should focus on strengthening the therapeutic alliance. Mr. Miller's inability to conform to structured systems, such as those imposed by employment and social relationships, is a fundamental aspect of his disorder and will always be a factor in his treatment. Rewards like food vouchers, clothing, bus tokens, and hygiene products are much more likely to improve compliance than are punitive measures. If down the line Dr. Jacobson becomes concerned about worsening psychotic symptoms that could lead to potentially aggressive behavior, then inpatient hospitalization is the appropriate decision because it will provide an opportunity to directly treat the underlying condition.

In sum, outpatient commitment creates potentially difficult therapeutic situations. With a patient like Mr. Miller, however, whose psychiatric disorder has led to recurrent social and legal problems, it can be argued that outpatient commitment is the only tool that will afford the opportunity for psychiatric treatment. In the absence of coercion, Mr. Miller will not adhere to treatment, and without it he will continue to have social and legal problems.

Many aspects of Mr. Miller's behavior will be difficult to understand, and those who treat him must be careful to avoid paternalistic assumptions regarding some aspects of his current situation. For example, some individuals choose to be homeless even when provided safe, individual housing. Therefore, the treating team must recognize Mr. Miller's impaired judgment but respect his right to self-determination. Certain aspects of his behavior, however, require clinical attention. Mr. Miller's paranoia and verbally aggressive behavior, for example, should be interpreted as the result of depression, fear, and anxiety. Ultimately, the goal of his treatment should be to relieve the symptoms that often remain unarticulated in patients like Mr. Miller. By using his mental well-being as the frame for treatment and recognizing his need for dignity, outpatient commitment is an intervention that can achieve therapeutic goals.

Scott C. Fears, MD, PhD, is a psychiatrist currently appointed as the Daniel X. Freedman Scholar in the Semel Institute for Neuroscience and Human Behavior at UCLA. A basic science researcher, he is interested in identifying genes that underlie brain structure and complex behavior. His experience with homeless individuals began when he was the director of psychiatric services at Homeless Healthcare Los Angeles from 2004 to 2007. Dr. Fears is a board member of the Integrative Recovery

Network, a nonprofit organization with a mission to establish long-term housing, social services, and mental health care to homeless individuals in Los Angeles.

Commentary 2

by Ann Hackman, MD

Outpatient commitment is a mechanism used in nearly 40 states that requires people to be adherent with mental health treatment. In our case, Dr. Jacobson's dilemma is representative of many of the problems associated with outpatient commitment that make this intervention a poor solution for individuals like his patient, Mr. Miller. For example, although Mr. Miller had appeared more anxious and irritated during sessions, he had not exhibited psychotic symptoms or seemed threatening or assaultive. He had not relapsed in either cocaine or marijuana use and had been taking his prescribed medications. He was adherent with all aspects of treatment except for getting to appointments on time.

Since the start of his outpatient commitment Mr. Miller had not been charged with a crime. There is only the slightest indication of exacerbation of psychiatric symptoms, and clearly Mr. Miller would not meet criteria for inpatient civil commitment (which typically requires that a person be gravely disabled or dangerous to self or others). Yet under the conditions of outpatient commitment, Dr. Jacobson could report Mr. Miller's repeated lateness for appointments and his fabricated excuse. These conditions would most likely result in the issuance of a hospital warrant, the police handcuffing Mr. Miller, taking him into custody, and an involuntarily hospitalization, possibly for an extended period.

Although the details of this case suggest that the requirement that Mr. Miller participate in treatment may be related to prior criminal charges, outpatient commitment is typically the result of a civil action rather than a criminal one. Outpatient civil commitment allows a person diagnosed with mental illness to be mandated to treatment on the basis of his or her potential dangerousness. It is usually applied to individuals who do not have guardians and who have been deemed by the court to be incompetent to make their own decisions. When the individual fails to comply with treatment requirements (e.g., keeping appointments, taking medications, attending programs, or living in a location designated by the court), he or she may be taken into police custody and confined to an inpatient psychiatric facility.

Those under outpatient commitment need not break the law or display dangerousness or grave disability to be committed involuntarily to inpatient hospitalization. In some states, outpatient civil commitment can be extended repeatedly for periods of up to 6 months without clear criteria for discontinuing the order [1]. Some proponents of outpatient civil commitment argue that it should be applied to anyone with a serious mental illness who lacks insight into that illness and is at risk for becoming homeless, incarcerated, or committing acts of violence including suicide [2].

Perhaps the most significant ethical concern with outpatient civil commitment is the violation of autonomy and civil rights based on the possibility of future dangerousness. Many consumer groups, some mental health professionals, civil-liberties groups, and the Bazelon Center for Mental Health Law oppose outpatient civil commitment on the premise that a person who is competent and not currently dangerous has the right to determine the course of his or her treatment [1]. Despite the fact that a majority of states have laws allowing outpatient commitment, a thoughtful consideration of the issue by Allen and Smith indicates that Supreme Court rulings including *O'Connor v. Donaldson* and *Addington v. Texas* seem to argue that it is unconstitutional [1, 3-5]. Outpatient civil commitment appears not only to violate the rights of a competent, nondangerous person to refuse treatment but may also violate such constitutional rights as the rights to travel, privacy, freedom from restraint, and free communication of ideas [6].

Proponents of outpatient commitment state that individuals with mental illness often have impaired insight, which justifies use of the commitment as a mechanism for enhancing compliance [2]. This viewpoint dismisses the very real problems and side effects associated with psychiatric medication. Proponents also point to evidence that outpatient civil commitment improves outcomes and decreases violence and hospitalizations [7, 8]. The same may be true, however, of adequate, *unforced* treatment programs. One study indicated that outpatient commitment was no more effective than enhanced and coordinated services in reducing risk of violence and arrest [9].

Too often outpatient civil commitment is a response to an inadequate mental health system. There is every reason to believe that Mr. Miller, who has engaged with treatment, will benefit from it. For example, he might receive Assertive Community Treatment (ACT), an evidence-based program of extensive care-management services. Instead, Mr. Miller is subjected to outpatient commitment and the requirement that he comply with all treatment expectations. It is no surprise that he is having difficulty or that more than two-thirds of people who are homeless and have mental illness struggle with adherence, particularly medication adherence [10]. Mr. Miller is staying in a shelter and is not likely to have a safe place to keep his medications or means to follow instructions (such as take after meals or with water). He almost surely lacks a calendar to help him keep track of appointments or family or friends to facilitate his being punctual.

Considering these circumstances, how could Mr. Miller be expected to meet all of the conditions of his outpatient civil commitment? Further, outpatient civil commitment may sabotage the ability of mental health professionals to build a therapeutic relationship with Mr. Miller. This may be particularly true if he is forced to take medications that cause substantial side effects, such as sedation, which, while mildly problematic for a person who is not homeless, is difficult to manage for someone who is.

My opposition to outpatient civil commitment is not a rejection of all forms of forced treatment. If Mr. Miller were currently dangerous—making threats, harming or trying to harm himself or someone else—or impaired enough that he could not care for his own basic needs, emergency involuntary hospitalization might be in order. If he had co-occurring dementia or otherwise lacked the capacity to make decisions for himself, he could appropriately be found incompetent by a court and have a guardian appointed to make decisions for him. If he committed a crime he might plead guilty and, in lieu of jail time, agree to treatment as a part of his probation. Or he might commit a crime, agree to plead not guilty by reason of insanity (or not criminally responsible), and, if the court made such a finding, have extensive treatment expectations as part of a conditional release.

Absent of any of these circumstances, however, I hope that even the most adamant proponent of outpatient commitment would not report Mr. Miller for being 20 minutes late to his appointment—with the potential consequence of involuntary hospitalization—regardless of his unsubstantiated excuse. Individuals who are mentally ill experience significant barriers to care [11]; for those who are homeless these barriers seem almost insurmountable. When getting up and dressed and taking public transportation to an appointment are compounded by homelessness, not to mention mental illness, how can Mr. Miller be expected to be fully adherent with treatment? Not considered here are medication side effects—possibly sedation, tremor or other abnormal movements, and increased appetite—that can cause even more distress for a person on the streets than for a domiciled person.

What would probably serve Mr. Miller better than outpatient commitment would be assistance in finding a safe place to stay, perhaps at a Safe Haven (a HUD-funded, transitional-housing program for people with mental illness who are homeless and engaging in treatment). There he could receive two meals each day and have access to toilet, shower, and laundry facilities. His medications would not be administered, but they would be monitored. One expectation for Safe Haven residents is that they work with a mobile treatment team, such as ACT, in return for case-management services, assistance with obtaining entitlements such as Supplemental Security Income (SSI), medical assistance, and medication coverage. If Mr. Miller did not attend a scheduled meeting, the team would come to him, and he might easily be persuaded to take medications and adhere to treatment.

Outpatient commitment may in some instances be seen as a short-term solution to a long-term problem, but it constitutes an unacceptable violation of the rights of competent and nondangerous people with mental illness. There are other effective mechanisms for engaging people like Mr. Miller without violating his autonomy and civil rights.

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Related in VM

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CLINICAL CASE

A Mother and Infant with No Home

Curren Warf, MD, MEd

Mrs. Patterson delivered her child by cesarean section in a community hospital. She and her child were in good health and ready to be discharged 2 days later. In speaking with Mrs. Patterson, Dr. Blake discovered that she was homeless, a fact that no one else in the hospital knew. When admitted, Mrs. Patterson had given the registrar an old driver's license and did not report that she was currently living in her car and staying with friends occasionally.

When Dr. Blake asked her what she intended to do once she left the hospital, Mrs. Patterson explained that she would not go to a shelter—she was afraid of random violence, substance abuse by fellow tenants, and unsanitary conditions. Friends offered her periodical financial assistance but not a permanent place to stay. Contacting her family or husband, who had been physically abusive, were not options, and she was adamant that social workers not be involved. She planned to live in her car until she could get back on her feet, which she said would only take a few months.

Dr. Blake was conflicted about what to do. On the one hand, she understood why her patient did not want to return home or stay in a shelter. She did not want to put her child in foster care. Even though Mrs. Patterson was mentally sound and competent, a patient could not be discharged without someplace to go. Communities were cracking down on the practice of “patient dumping.”

Commentary

This is an interesting case that raises many issues pertaining to both the mother and the infant as well as policies that shape the problem of homelessness in America. The probable gulf in life experience between the evaluating physician and her patient creates a clear potential for judgments to be made based on the biases of the physician and a lack of understanding or appreciation of the circumstances of the homeless mother. The gap can be exacerbated further if there are differences in ethnicity. Thus, it is essential that Dr. Blake be aware of her own biases and susceptibility to stereotyping and respect her patient's autonomy in making ethical and management decisions.

The definition of homelessness is critical to clinical evaluation; the development of prevention and intervention programs and federal- and state-funding decisions all depend on it. The McKinney-Vento Act of 1987, which was renewed in 2002 and is followed by the U.S. Department of Health and Human Services, defines a homeless

person as “an individual who lacks a fixed, regular, and adequate nighttime residence” [1]. This includes not only individuals who are living on the street but also those who live in shelters or are temporarily staying with friends. Mrs. Patterson fits this description.

Dr. Blake’s concern in discharging the infant to a homeless parent is understandable given the accompanying risks—most the result of lack of health services and exposure to environmental and social dangers found in shelters and substandard housing. Homeless children are more likely than poor, housed children to be hospitalized or visit an emergency department; they are twice as likely to get sick, four times as likely to have asthma, and over six times more likely than poor, housed children to have multiple health problems. They are five times more likely to have infections associated with crowded living quarters such as upper respiratory infections, scabies, and diarrhea. Homeless children go hungry twice as often as nonhomeless children and are twice as likely to repeat a grade in school. Playing in unconventional areas puts them at higher risk for injury and toxic exposure, and they have higher rates of lead poisoning and lower rates of lead testing than comparable housed, low-income children because of time spent in dusty, dilapidated shelters [2, 3]. Homeless children also have delays in immunizations and access to treatment for acute and chronic medical conditions.

Every year 600,000 families with 1.35 million children, or about 1 in 50 American children, experience homelessness [4, 5]. Homeless families are the fastest-growing segment of homeless people, now making up about 40 percent of the homeless population on any given night [6]. They are typically headed by a single parent—about 85 percent are single mothers with children [7]. Homeless children are homeless on average for 10 months at a time, and about 25 percent have been homeless more than once [8]. With the current economic crisis, the inevitable increase in unemployment, and expiration of unemployment benefits, homelessness of adults and children will undoubtedly rise significantly in the coming years.

In Mrs. Patterson’s world, the demand for subsidized housing outstrips its supply, the federal government has failed to promote low-income housing since 1980, and broad economic forces beyond the control of any individual appear to be framing her homeless status. Her experiences with trauma and loss may shape her emotional responses, mental health, or substance use. Intimate partner violence has profound effects on mental health and behavior, not only of the immediate victim, but for children that witness these relationships. Those children are sometimes referred to as “invisible victims” since, when the problems are brought to the attention of physicians, social workers, police, or others, the focus is generally on the evident problems of the adult, and the child’s needs are commonly neglected [12].

Right to Autonomy and a Child’s Best Interests

The mother’s right to autonomy must be balanced against the need to assure the safety and well-being of the infant. In general, parents are presumed to act in the best interest of their children and hold the legal and ethical right to consent for them in

health care and housing matters. But parental right is not absolute, and the capacity of a parent to act in the best interest of the child must be assessed. Defining the best interests of the infant can be complex, given both his or her physical safety and security and the threat to disruption of early attachment to the mother. Nurturance and stability of attachment during the first years of life, when essential characteristics such as the capacity to love and trust are developed, are critical to emotional health.

Emotional development and growth are largely mediated through the stability and consistency of attachment to the primary caregiver, usually the mother. Even though the mother may be able to supply only an unstable physical environment for the infant, she may be the person most capable of providing a stable emotional bond. Given the complete dependence of the newborn on the adult caregiver, it is important to make a critical assessment of Mrs. Patterson's competency. Many of the problems that Mrs. Patterson confronts are related to a lack of resources, family and social supports, and stable living environment. Stabilization in housing can create circumstances far more conducive to the child's development and safety—though it seems evident that Mrs. Patterson and her infant could also benefit from mental health services, parenting classes, and other supportive services.

Mrs. Patterson declined an offer to go to a shelter for several reasons such as lack of safety, violence, and substance abuse that staff of homeless shelters are generally well aware of, especially as they affect small children. Many times, women with children are put at the head of the line to be afforded more desirable housing including vouchers for hotels or apartments as they become available. Although the hospital may have capacity and finance concerns, it would be unconscionable to discharge a new mother and her infant to an obviously unsafe environment. Among all the possibly conflicting interests at stake—the infant's, the mother's, and the hospital's—Dr. Blake must decide which has priority. Given Dr. Blake's work situation in the hospital, she may experience overt and covert pressures to put the hospital's interest above the patient's, depriving the patient of her most important advocate. Because of such pressures, many states have laws to protect indigent patients from discharge to the street.

Determining Available Options

Quite likely Dr. Blake does not know what services and placement options exist for homeless mothers in the local community. In that case, she must identify sources that are knowledgeable about local shelters that can house mothers with infants or alternative placements such as maternity homes or extended family members. Many communities in the United States, particularly in urban centers, have dealt with homelessness for decades and have such resources.

Mrs. Patterson is adamant that social workers not be involved, but we aren't told why. Dr. Blake can ethically and legally notify a social worker despite her patient's insistence not to involve one if she sees a probable cause to do so. Homelessness carries with it great stigma; homeless people are subjected to both the disapproval and judgment of others and to being stereotyped as mentally ill, criminal, or

substance abusers, all of which are commonly inaccurate; they may experience fear, loss of pride, and dependency on others. But perhaps what Mrs. Patterson most fears from involvement of a social worker is the loss of her child. It is reasonable for her to be suspicious of the motives that physicians, social workers, and others have when they question her.

Conclusion

In the end, it is the infant who is most vulnerable in this situation, and whose interest Dr. Blake must place above others. Physicians are “mandated reporters” of suspected child abuse and neglect. These reports are made to Child Protective Services (CPS) in the county in most areas. There are regional differences in the availability and quality of services to families through CPS, but homelessness is not a criterion for removal of a child. In the more advanced systems, however, which exist in many urban areas, CPS can work with the parent toward supervised stabilization including kinship care where children are placed with extended family members in preference to strangers in foster care, and provided additional supportive services.

It is possible to argue that the infant should be removed from the custody of the mother because of her homeless status and placed in child-protective custody, despite the lack of evidence of child neglect or maltreatment. This approach would certainly carry the risk of bringing about significant unintended, if predictable, consequences. Poverty and homelessness do not equate with maltreatment or neglect and are not in themselves a basis for removing a child from his or her parent. Though placement in CPS may seem like a facile response to a complex situation, and could ultimately even be the path that is chosen if a significant risk of child endangerment can be identified, placement in the system puts development of early attachment of the infant and mother in jeopardy. If placed in CPS, it is likely that the child will have multiple changes in housing and caregivers and repeatedly disrupted early childhood attachment. Finally, if placing the children of homeless women in foster care becomes the practice of the hospital in addressing this problem, it is unlikely that other homeless women would choose to deliver their babies in such a facility.

Homelessness affects every major U.S. urban area and many smaller ones. It is a complex issue that carries a threat not only to the physical health of those affected, but to their long-term social and personal development. Though mental health problems and substance abuse do play a role in initiating and prolonging homelessness for some, these are not the predominant problems for the vast majority of homeless people, and reflect to a large degree the inadequacy of current mental health services. Many people confront a period of homelessness in life, and for most it is a temporary, not chronic problem. Physicians are frequently the individuals who make the first link toward stabilization.

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CLINICAL CASE

Hospital Resources: A Practical Treatment Plan for Homeless Patients

Commentary by James Dunford, MD, David Buchanan, MD, MS, and Sharad Jain, MD

On a bitterly cold January evening in New York City, Mr. McCaffrey, a 63-year-old homeless man well known to the hospital, came into the emergency room complaining of generalized weakness, intense pain on coughing, and pain suggestive of a heart attack.

Dr. Edwards, a first-year resident, interviewed Mr. McCaffrey, consulted with the attending physician, and subsequently ordered a number of tests. All tests were negative, suggesting that Mr. McCaffrey did not have a heart attack.

Dr. Edwards began to suspect that her patient was malingering. She spoke with Mr. McCaffrey, who confessed that he was hungry and didn't want to endure the cold weather outside. It was clear that Mr. McCaffrey was in suboptimal health because of his homelessness and age and it was quite possible that, if the hospital were to put him on the street, he might return as a result of a heart attack or with pneumonia.

Should Dr. Edwards tell Mr. McCaffrey to leave because using the emergency room for non-medical purposes drains resources (e.g., time, patient rooms, and caregiver energy) or does she decide that, as a healer, she should provide him with the basic elements of survival? How far should Dr. Edwards go to check out his complaint each time he shows up? What should the treatment plan be for this returning patient?

Commentary 1

by James Dunford, MD

I know Mr. McCaffrey. He has bipolar disease and routinely visits my emergency department. After his wife died he lost his job, started drinking again, and now lives behind a store in an alley. When he's not in jail for illegal lodging or public intoxication, he is at detox or in our emergency department. When paramedics call to announce his arrival, someone invariably says, "When are they going to do something about Mr. McCaffrey?" The emergency-department staff at our sister hospital knows him just as well as we do.

Usually one of his friends calls 9-1-1 if he mentions shortness of breath or chest pain. He often spends 4 hours in an acute-care bed awaiting lab results, x-rays, a CT scan, and a meal. When he is sober enough to walk to the bathroom he usually wants to leave. Every visit represents at least \$1,000 in uncompensated care, and those

visits now total more than 50. Social workers refer to him as noncompliant. He explains that he simply hates shelters because they are dangerous and his backpack is always getting stolen. Last winter he was admitted for pneumonia and had a non-ST segment elevation myocardial infarction (non-STEMI). He did well on mood stabilizers until discharge but never followed up with a physician. It's no surprise that staff feel frustrated and even angry whenever he arrives. Now, on this icy cold night a young resident named Dr. Edwards is assigned to Mr. McCaffrey, who has come in complaining of chest pains.

Since the passage of Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, emergency departments in the United States have progressively become medical-care providers of last resort for millions of individuals. Emergency departments operate around the clock and are an essential component of the public health safety net. Unfortunately, the resources to meet the needs of all emergency-department patients are rarely available—particularly on nights, weekends, and holidays. The case of Mr. McCaffrey illustrates how emergency physicians can find themselves with an empty toolbox and must compromise to meet their responsibilities to patients and themselves.

As physicians, we are guided by ethical values that include beneficence, nonmaleficence (i.e., do not harm), respect for autonomy, justice, dignity, truthfulness, and honesty. You're not likely to hear the nuances of these terms debated in a busy emergency department, but they do direct the proper approach to all good decision making. Clinical medicine teaches that we begin with a careful history and physical examination to derive an accurate differential diagnosis and thoughtful plan. From the initial vital signs to a final review of lab results, we search for clues, employ pattern recognition, weigh risk, and attempt to match resources with perceived need.

Mr. McCaffrey's evaluation should follow the same procedure. Emergency physicians often work backwards from worst- to best-case scenario, particularly when evaluating patients with complaints like chest pain that can represent a life-threatening condition. Since emergency care is episodic rather than long term, it is imperative that Dr. Edwards start off on the right foot with Mr. McCaffrey. Her first words and mannerisms must convey a sense of caring. "Hello Mr. McCaffrey, my name is Dr. Edwards. How I can help you today?" They should reflect genuine concern if she is to convince him of any future recommendation. She must also avoid bias from prior references to "frequent flier" that may appear in his medical record. To maintain objectivity, her next question should be, "What is different tonight that made you come to the emergency department?" The answer to that question defines the trajectory of the work-up and sets the goals of the encounter.

In 2008, the minimum standard work-up for a 63-year-old man with a prior non-STEMI and ischemic-sounding chest pain is a 12-lead ECG, chest x-ray, and a 6-hour set of cardiac markers. This is the recommendation regardless of the number of the patient's prior visits to the emergency department unless a recent angiogram has

ruled out significant coronary disease. After Dr. Edwards excludes acute coronary syndrome and its mimics, her job is to develop a final disposition for Mr. McCaffrey by weighing his chronic medical, social, and mental health conditions. She recognizes his unfortunate circumstances and, given that it is midnight, neither she nor he wants to see him return to the icy streets. He may have survived the past 10 years on those streets but his chronic homelessness (i.e., continuous homelessness for over 1 year) places him at increased risk for premature death [1]. Tonight, he simply has acute bronchitis, but he could once again develop bacterial pneumonia. The real problem is that a combination of homelessness, poverty, and untreated mental illness has trapped him in a revolving door that opens only to the streets, jail, detox, and the emergency department.

The number of individuals like Mr. McCaffrey who are being cared for in U.S. emergency departments every day is relatively small but these frequent users of services consume enormous acute-care resources without appreciable gain [2]. They repeatedly visit emergency departments rather than primary care clinics with complex needs that cannot be addressed in this setting, and emergency physicians are at a loss to provide anything but short-term solutions. They face daunting barriers to medical and mental health care, substance abuse treatment, and housing, and, as a result, disproportionately tax the time and resources of police, fire, jails, emergency shelters, businesses, and courts.

Until recently, little consideration has been paid to the problems of this population. Over the last 5 years, the Boston HealthCare for the Homeless Program identified 18,834 emergency department visits by 119 chronically homeless individuals [3]. And over 4 years, 529 chronically homeless alcoholics in the San Diego area amassed 3,318 emergency department visits, 652 hospital admissions, and health care bills totaling \$17.7 million [4]. In Washington during 2002, 198 of the 130,000 participating adults generated 9,000 emergency department visits and consumed 19 percent of all Medicaid expenditures [5].

Fortunately, some communities are testing novel approaches for these patients. The San Diego Serial Inebriate Program (SIP) provides housing and treatment in lieu of custody to chronically homeless people who are alcoholics [4]. From 2000 to 2003, SIP reduced episodic emergency department visits, improved rates of sobriety, and produced cost savings of more than \$70,000 per month. The California Frequent Users of Health Services Initiative published the results of six separate county pilot programs [2]. When patients were connected with housing, income benefits, health insurance, and a primary care home, a 61 percent decrease in emergency department visits and a 62 percent decrease in inpatient days occurred over 2 years.

Unfortunately, Dr. Edwards has no such program at her disposal. She needs a utilitarian, short-term plan so she can see her next patient. In this situation, the principle of *primum non nocere* (first, do no harm) guides emergency medicine decision making. Dr. Edwards must exclude any plan that carries undue risk of further injury. She should reassess her patient's physical and mental capacity and

employ basic common sense to assess his ability to function. For example, if Mr. McCaffrey cannot walk without assistance, he requires admission.

If Mr. McCaffrey can ambulate independently, his needs on this night are essentially shelter and food. Dr. Edwards must also assess his decision-making skills to be certain there is no reason to hold him involuntarily. If he possesses the basic faculties to care for himself, she can fashion a solution that provides both temporary shelter and a bridge to further care. Given the fact that the emergency department waiting room is full (and assuming no emergency shelter is available by cab) she should consider discharging him to the hospital lobby until morning. Provided her attending is in agreement, she should notify hospital security and the nursing staff of her plan. Next, she should explain to Mr. McCaffrey that she believes this is the best among a limited set of options and seek his approval. She should place a referral for a social work consult in the morning, request an outpatient cardiology evaluation of his chest pain, and document their discussion.

At least for 1 night, Dr. Edwards can feel satisfied she has provided Mr. McCaffrey with safety. She can take less comfort from the realization that this scenario is likely to be repeated. A more satisfying solution for Dr. Edwards would be to discuss this case at a departmental conference. Greater awareness of the extraordinarily negative impact of even a single frequent user like Mr. McCaffrey can result in systemic improvement [6]. By opening a discussion of frequent users, she will most likely identify other champions for change of the unacceptable status quo.

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Commentary 2

by David Buchanan, MD, MS, and Sharad Jain, MD

Homeless patients are at high risk of early death and Mr. McCaffrey, at 63 years of age, has already exceeded his life expectancy by 15 to 20 years [1, 2]. Patients with legitimate hunger and shelter needs often also have serious health problems. If they are not evaluated based on their symptoms because of concerns that they are malingering, they can suffer bouts of severe illness or even death.

There is general agreement that the ethical principle of justice entitles individuals to a decent minimum of health care. We believe this decent minimum involves access to social services that might help Mr. McCaffrey. Given the belief that Mr. McCaffrey's health will suffer if he is sent back to the street on a frigid night, it is imperative that his caregivers do what they can to prevent him from facing that consequence.

Beyond the decent minimum standard, there are emerging models for health care delivery which both meet the true needs of a homeless patient for housing and decrease the use of emergency departments and inpatient services. These models include respite care and hospital-to-housing programs.

Respite care is a form of interim housing for homeless patients who suffer from acute medical illness or injury. Compared to traditional community housing, respite centers employ staff who can admit patients rapidly after they are seen in an emergency department or after hospital discharge. Compared to emergency shelters, respite centers' workforce can assist homeless patients who are recovering from acute illness or injury, and the centers allow patients to stay in the facility 24 hours a day to promote recuperation from the acute illness or injury. As a result, they fill an important niche in providing housing to individuals like Mr. McCaffrey. Currently, there are 45 respite centers in the United States according to the Respite Care Providers Network, and the number grows each year. Referral to respite care for homeless inpatients has been shown to reduce re-admissions during the following year by 49 percent, demonstrating that effectively managing the patient's social needs can significantly decrease re-hospitalizations [4].

Hospital-to-housing programs are an emerging, but less common approach that has proved successful. They refer patients directly from hospitals to permanent, supportive housing. Some existing hospital-to-housing programs are designed for frequent emergency department users such as Mr. McCaffrey. A trial of the programs in Chicago documented that patients with HIV had significantly lower viral loads when given access to housing. Respite care and hospital-to-housing programs are on the rise and appear to be the most effective strategy for managing medically ill homeless patients who routinely visit the emergency departments and hospital.

Physicians are also ethically obligated to advocate for improved health delivery systems. If the hospital in which Dr. Edwards works does not have adequate social services, it is important for her to discuss this deficiency with her supervisors and hospital administrators. She could argue that the decent minimum of health care was not available for her patients and the system needed to establish services to address this shortcoming. It is her responsibility to do so if she feels that she does not have the support to adequately manage her patients.

Dr. Edwards is a first-year resident; her residency-training program has an educational obligation to teach her the skills she needs to help patients like Mr. McCaffrey. The curriculum should ensure that she learns general principles of interdisciplinary care and has knowledge of resources available in the hospital and community to promote patients' health. It is imperative that students understand the roles of the health care team and ways in which they can work together to optimize care for their patients. The Accreditation Council for Graduate Medical Education, for example, explicitly states that, as part of the competency in systems-based practice, residents must learn to work in interdisciplinary teams to enhance patient safety and improve patient care quality [3].

The physician evaluating Mr. McCaffrey should take his medical concerns seriously, given the increased morbidity and mortality in homeless individuals. Once his medical problems have been addressed, Mr. McCaffrey should be referred to a social worker with specialized knowledge of services available in his community—hospital-to-housing and respite care are two examples. Physicians have the responsibility to learn about these resources and advocate for their existence in their practice setting.

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ON CALL

Resources and Responsibility

Commentary by Jake Richards

Mr. F was a veteran construction worker living with his wife and two children when, in 1989, he developed severe back pain and rapid onset of paresthesias, pain, and limited mobility in his lower extremities. He was diagnosed with a primary spinal epidural non-Hodgkin's lymphoma (NHL) and underwent laminectomy to relieve spinal compression. But the nerve damage was severe and Mr. F continued to experience peripheral neurological deficits, including persistent pain.

Mr. F's pain was managed on methadone, which has the advantages of being a long lasting agent as well as inexpensive. His chronic pain prevented him from returning to work, and the family's only source of income was his Social Security disability check, which was frequently not enough to cover all of their expenses. Mr. F's NHL recurred in 1998 as a localized cranial tumor ("the size of an orange"). After undergoing a partial skull excision with follow-up chemotherapy, Mr. F began experiencing depression; financial strains forced him to sacrifice or space out his pain medication refills. During these gaps, he started to rely on alcohol to treat his pain. Methadone accentuates the effects of sedative hypnotics, such as alcohol, so Mr. F quickly developed dependence. The financial stress combined with alcohol use led to his wife's leaving him, and, with only his disability for income, he became homeless.

Over the next 4 to 5 years, Mr. F moved among local shelters. Many shelters prohibit or enforce strict limitation on use of narcotic pain medications, and drove Mr. F to use high levels of alcohol as he attempted, in effect, to achieve the sedation of alcohol+methadone). In 2004, Mr. F was diagnosed with severe cirrhosis secondary to viral (B/C) and alcoholic hepatitis. In 2006, variceal rupture led to his first GI bleed, and he has been in the hospital ED six times since for upper and lower GI bleeds and many additional times for alcohol intoxication.

During one of his encounters for persistent upper and lower GI bleeding, Mr. F was admitted to the ICU with a severely low hematocrit and hypotension. Bleeding could only be controlled with local injections of epinephrine throughout the GI tract. The evening after admission, Mr. F developed refractory tachycardia requiring electrical cardioversion. The resident on call remarked that the patient's only hope was a liver transplant, even though he "obviously" was not eligible. The resident spent the rest of the night calling area hospitals pleading with them to consider Mr. F for a TIPS procedure.

It is evident from Mr. F's liver function tests that he received the TIPS procedure. He has been admitted to the ED at least three times since for alcohol intoxication and, each time, is treated as a "frequent flyer" with no consideration or mention of his fragile state (i.e., increased risk of hepatic encephalopathy, etc.).

Questions for Discussion

Who is responsible for Mr. F's current state of health? To what degree should our resources be allocated to treating Mr. F? Are we simply waiting for him to die?

Commentary 1

by Jake Richards

We can approach these three questions about Mr. F's care through the lenses of justice, utility, and recidivism. The principle of justice forces us to ask who is responsible for Mr. F's current state of health; utility focuses on the effectiveness of decision making and resources being allocated now, and what we know about recidivism in those who abuse alcohol cautions us to think even more carefully about future resource allocation [1,2].

In the early 1990s, there was widespread belief that alcoholics should have lower priority for transplantation than patients with "non-self-induced" causes of liver disease. The implication was that alcoholics were responsible for their self-destructive behavior and, hence, for their disease [3]. This attitude is expressed by the ED staff each time Mr. F presents with alcohol intoxication. Considering Mr. F's history, however, this perspective does not seem just. His alcoholism is secondary to inconsistent pain management, which was influenced by his financial and social position. His use of alcohol as pain control can be further reduced to the complications from NHL, which Mr. F cannot fairly be held personally responsible for. Was his illness "bad luck?" If it was simply bad luck, then does that give us the right to give up on him now? Moreover, if he *were* personally responsible, would we have the right to give up on him now? Or is medicine a practice in which compassion tempers justice?

On the other hand, chronic peripheral pain is a known complication of prolonged spinal stenosis, and there is no guarantee that a liver transplant would reverse his symptoms. Once Mr. F's pain caused social and financial problems, management of his situation exceeded the bounds of a 15-minute primary care visit. Furthermore, Mr. F relied on the ED for medical care. Rarely can an ED physician, who is pressured to triage and treat as many people as possible, set aside time to connect a patient like Mr. F with his family, the various shelters, and other social services to assure appropriate pain management.

Rather than looking at the past and attempting to establish responsibility as a means of guiding care and resource allocation, maybe it is more appropriate to focus on current decision making. According to the residents who followed Mr. F, a liver transplant was not even an option. But 7-year post-transplant survival rates of patients with alcoholic liver disease (60 percent) is comparable to (slightly better

than) those of patients transplanted for other causes (76 percent biliary cirrhosis; 57 percent hepatitis C; 49 percent hepatitis B; and 27 percent hepatocellular carcinoma) [4]. Mr. F also carries diagnoses of “non-active” viral hepatitis C (determined by quantitative DNA analysis) as well as a recurrent non-hepatic malignancy treated with two rounds of chemotherapy. Alcoholism has no effect on viral replication [5] and he does not have any signs of NHL recurrence, so these factors should be considered independently of his alcohol. Considering his diagnostic prognoses, should not a liver transplant be an option?

Many of the arguments against allocating care to certain groups in society focus on the principle of recidivism, or the likelihood of repeating self-destructive acts. While alcoholic recidivism does occur it has been shown not to affect compliance to treatment or graft outcome [6]. Neither a liver transplant nor a TIPS procedure will affect Mr. F’s severe paresthesias, the pain in his lower extremities, or his ineffective pain management. It is not surprising that he continues to consume alcohol. Should this abuse preclude his access to limited and costly resources when, to be fair, he is in this situation because adequate resources were never made available to effectively treat his primary problem of lower extremity pain. At that point, he was not abusing alcohol or participating in any other known self-destructive acts. Why was the health care system unable despite his countless visits to the ED to effectively treat his pain? Did anyone try? Was Mr. F evaluated for surgical pain control intervention? Was he referred to a chronic pain clinic?

A liver transplant is not an option for Mr. F, and TIPS is not a cure—it is simply a band-aid. It will stop the bleeding, but at the cost of increasing his risk of alcohol toxicity because alcohol is effectively shunted through the liver and to the body (particularly the brain). More importantly, the TIPS will not reduce his pain. Justice, utility, and recidivism—many will use these approaches to inappropriately justify Mr. F’s care, but a true examination of his predicament highlights the lack of accountability on the patient’s part and on the part of health care professionals over the years—and it will cost Mr. F his life.

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Jake Richards is the pseudonym for a third-year medical student at Harvard Medical School in Boston.

Commentary 2
by the MSS Committee on Bioethics and Humanities Response

Mr. F' story is tragic, but unfortunately not uncommon. Two important issues are raised by his case: responsibility for health status and scarce resource allocation.

In terms of responsibility, as the case commentary highlights, it is often suggested that individuals who are “morally responsible” for their illnesses (and, therefore, their health needs), and may have been able to avoid them through different decision making, have a weaker claim on social resources than do individuals whose health needs are no fault of their own. Wikler describes an approach towards assessing individual responsibility for health needs in 2002. To be assigned individual responsibility for one's needs, Wikler said:

- (a) the needs must have been caused by the behavior
- (b) the behavior must have been voluntary
- (c) the persons must have known that the behavior would cause the health needs and that if they engaged in it their health needs resulting from it would receive lower priority [1].

Such criteria are not easily satisfied, especially in cases of substance abuse and the influence of barriers to health care related to lower socioeconomic status. In the present case, for example, was Mr. F's health need created both as a result of his alcoholism and as a consequence of the medical system's inability to offer effective pain management? The patient's homelessness and continual lack of health resources such as primary care, can also be considered contributing factors. In other words, analysis of the case from a micro (patient) and macro (society and medical system) perspective results in two sources of accountability, and either by itself is insufficient in accounting entirely for the decisions patients make. And, as the case commenter suggests, delivering care based on determined responsibility is not within the norms or goals of medicine. The medical profession is one in which needs are evaluated and met whether or not an individual is deemed “deserving” of care.

This egalitarian approach, however, is not always practical when allocating scarce resources and evaluating cost-effectiveness. Here the question is should higher priority be given to people who can be treated more efficiently and cheaply. Immense costs and resources are required to treat Mr. F adequately. Does that mean that he should not be treated or that he has less claim on scarce, valuable resources?

Alternatively, one can turn to potential benefit as a basis of determining just allocation. In other words, if resources such as a liver transplant or continuous monitoring of pain control were dedicated to this patient, how much would it prolong or improve his quality of life? How does this compare to allocating these resources elsewhere, such as giving the liver transplant to a nonalcoholic patient without hepatitis, or taking the immense resources required to treat his chronic pain and applying them in the treatment of ten or more patients whose compliance and follow-up care is better guaranteed? While these notions of “fair chances and best outcomes” are important to consider (and as the author describes, they are basis of current transplant allocation guidelines), it must also be recognized that they may compound existing inequalities. For example, as this case illustrates, patients of lower socioeconomic status tend to have higher comorbidities and worse prognoses than their wealthier counterparts who may have continuous primary care, better educational opportunities, and fewer barriers to compliance. Moreover, resources are not easily fungible in the way this “solution” suggests. Dollars and resources “saved” on one patient are not shifted to the care of tens of other, less complex cases. Health care financing just doesn’t work that way.

In sum, this case clearly illustrates how the complex dynamics between micro (patient-doctor) and macro (society) perspectives influence medical decision making. While a simple resolution may not be easy to determine, the case emphasizes the importance of considering social influences on a patient’s health including reduced socioeconomic status, homelessness, stereotyping, and lack of primary care and support structures.

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Call to Readers

To encourage responsible ethical debate and critical thinking, the AMA-MSS Committee on Bioethics and Humanities invites medical students to submit written responses to this case. Responses should be 800 words or fewer and should be sent as an e-mail attachment to oncall@ama-assn.org. Readers who submit comments must identify themselves by name, date of birth, and medical school so that their medical student status can be verified, but they may use a pseudonym as a signature to their comments. Letters will be published at the discretion of the AMA-MSS Committee on Bioethics and Humanities. Additional announcements will be posted on the committee’s website: <http://www.ama-assn.org/ama/pub/category/15539.html>.

Medical students who wish to submit cases and commentaries on upcoming Virtual Mentor themes should visit the On Call [Guidelines for Submission](#).

The facts of this case have been changed so that it does not describe the actual experience of the student-author or of a specific patient. Resemblance of the resulting case to the actual experience of a specific student or patient is coincidental.

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MEDICAL EDUCATION

Medical Student Self-Efficacy and Attitudes toward Homeless Patients

David S. Buck, MD, MPH, and Benjamin T. King

Perhaps it is the culture of many medical schools that encourages students to specialize in more “prestigious” and lucrative areas of medicine rather than pursue careers of service to indigent or homeless populations [1]. The frustrations of working in indigent health care often catalyze discouragement for continuing in such settings and worsen attitudes toward this population during the course of medical education [1-4]. These findings accord with reports that students become less humanitarian, more cynical, and more focused on career and practice goals during their training [5]. We believed that introducing students to care for homeless patients in a supervised experience in the Houston Outreach Medicine Education & Social Services (HOMES) Clinic would help reverse their negative attitudes toward homeless patients.

There are indications that adverse caregiver attitudes and a lack of understanding contribute to reduced access to and quality of care for the homeless [6-9]. These counterproductive qualities most likely stem from training that did not adequately prepare students and physicians to manage their own reactions to this population. Homeless patients who encounter these attitudes and behaviors seek health care less frequently, which often preempts early treatment and leads to late visits to emergency departments [7]. Negative attitudes perceived by patients also increase their sense of alienation, stigmatization, and despair. The result is a decrease in the effectiveness of counseling, treatment recommendations, and spiritual succor—the core of a physician’s therapeutic tools [10, 11].

Investigators in the United Kingdom demonstrated that, as in the United States, student attitudes were more negative at the end of medical school than the beginning. Semi-structured interviews of the students with the greatest changes in scores indicated that negative clinical experiences and professional socialization (including role models) were the determining influences [2]. Physicians, of course, share the attitudes and prejudices of their community and society, and the intertwining of negative attitudes toward the homeless sustains the ethos in both groups [11].

The quality of medical education depends on how the information is transferred and how professional socialization is experienced. Hence, it is critical that the students’ ethics, attitudes, and values are cultivated to guide their development as physicians who can treat all patients equitably. Socioeconomic background, serious mental illness, substance abuse, personality disorder, chronic pain, abuse, abject poverty,

and low social and intellectual functioning should not disrupt the patient-physician relationship.

Students who opt for subspecialties score significantly lower on the empathy scale than students who choose family practice, internal medicine, or pediatrics [12]. Another British study examined the attitudes of students interested in general practice (U.S. family medicine) when they were most likely to interact with homeless and low-income individuals seeking primary care services. The attitudes of these students, mentored by general practitioners, were more negative at the end of their medical education than at the beginning, a change that was attributed to the personal experiences they had with general practitioners [13]. Results starkly illustrate the influence of physicians' attitudes and how generationally transmitted they can be.

HOMES Clinic

Medical students' primary exposure to the homeless health care system in Houston is a free, student-run, primary care clinic initiated and organized under the charter of the Healthcare for the Homeless—Houston (HHH). From its beginnings, HHH has been intertwined with the development of the HOMES Clinic. The HOMES Clinic creates an experience different from the daily workings of a traditional clinic in that it is managed largely by medical students. It involves students from Baylor College of Medicine (BCM), the University of Texas (UT) School of Medicine, UT School of Public Health, and University of Houston (UH) College of Pharmacy—working together interprofessionally. Recently, the UH College of Social Work was invited to provide more comprehensive social-service referrals to our patients.

The clinic, opened in 2001, has evolved over the years. It operates on Sundays and is manned by four-member teams of two first-year medical students and a pharmacy or public health student, and led by a third-year BCM student participating in the Longitudinal Ambulatory Care Experience elective for homeless health care. The teams evaluate their patients during the day and present their reports to a medical-faculty preceptor who guides the treatment and emphasizes the social and economic aspects of health care, thus exposing students to a bio-psycho-social model of medical treatment [14].

Our program is designed to foster students' self-efficacy and encourage leadership. We emulate the social component of the University of California San Diego curriculum, where students share a meal with homeless persons and conclude each clinical session by reflecting with their peers, processing, communicating, and resolving the strong, emotionally challenging elements of this work.

Health Professionals' Attitudes Toward the Homeless Inventory

If attitudes are to improve, they must be quantified so that the effect of interventions can be gauged and evaluated. We used several studies that accurately and reliably evaluate the perceptions of public and health care professionals. The first was the Attitudes Toward Homelessness Inventory (ATHI), which demonstrates differences

in scores associated with previous experience with the homeless, personal experiences of being homeless, and any changes in attitudes over time [15].

Following publication of the ATHI, a survey measure designed specifically for medical students, the Attitudes Toward the Homeless Questionnaire (ATHQ), was published in the United Kingdom. ATHQ was derived from in-depth interviews with general practitioners. It was first used to show that second-year students who participated in a health and homelessness elective had more positive attitudes toward the indigent population than their peers in other modules [16]. Researchers later, however, noted a decrease in the positive attitudes of these medical students during their progression from the basic sciences through their clinical years [2].

To meet the need for a similar survey with terminology appropriate for the U.S. system of care, faculty and students at BMC designed, validated, and published the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI). This survey is considered an indirect measure of self-efficacy for students. Those who have learned how to be effective with the homeless naturally have better attitudes, while students with some experience but minimal skills are frustrated and have poorer attitudes. As in the U.K. survey, the HPATHI found that respondents with some experience had a less favorable attitude toward homeless people than those with no experience. We believe this finding represents the phenomenon of counter-transference in which a clinician projects his or her feelings onto the patient—a patient that the physician is unable to help is judged to be “difficult” or a poor historian.

Responses to the survey components were arrayed along three dimensions: personal advocacy, social advocacy, and cynicism. Comparing scores across groups showed there was no significant difference between preclinical medical students and primary care physicians, but those with more than 1 year of experience working with the homeless had higher overall attitude scores than health care professionals with less than 1 month [11]. After an initial reduction in positive attitude after slight experience (less than 1 month), more experience led to greater interest and more positive attitudes. Thus, the authors suggested that more direct, well-mentored patient care for the homeless be provided in the medical education curriculum. The next necessary method of measurement is to document change in attitudes over time in a given sample, which was accomplished by comparing changes in survey scores (all validated for reliability and test-retest stability).

In a more recent study, internal-medicine residents were evaluated with the ATHI and ATHQ surveys before and after a 2-week rotation in homeless health care. While both surveys showed a significant change in scores over just 2 weeks, the ATHI revealed a significantly larger (0.53) per-item change—after adjustment for differences in response scales—to 0.13 for the ATHQ [17]. Because the study tested both surveys for overall changes in scores relative to each other and not to a third measure, it was not intended to evaluate true attitudes or make a comparison of construct validities. It did not, however, illustrate that ATHI was the more sensitive

tool for detecting changes in attitudes from the beginning to end of an educational program.

We are currently concluding a study that examines these exact elements. In a prospective study, the HPATHI and ATHI are being administered to all participants during a first-year elective and at the beginning and end of a third-year homeless health care rotation at BCM. Differences in scores were assessed across demographics, between first- to third-year students (pre- and post-clinical experience), and from the beginning to end of the third year of medical school. Differences in scores between the HPATHI and ATHI will be examined for sensitivity to changes in attitudes.

At this time, the data seem to support previous findings. Taken prior to their homeless health care rotation, third-year medical students' attitudes toward the homeless appear to be lower than those of first-year students. Also in line with previous findings, students with 1 year or more of service to the homeless have slightly higher scores than those with 1 month or less experience with the population. These findings substantiate factors involved in medical student attitudes toward the homeless and confirm the benefits of providing students with positive experiences with this population. A sample of 20 third-year students who completed surveys before and after their rotation did not show a significant change in attitudes. These data suggest including more direct homeless patient care within the medical education curriculum to foster improvement in attitudes toward this population. Our next step will be to report on the efficacy of the HPATHI instrument as means of assessing students' attitudes and measuring the impact on the educational experience.

Protecting the Interest of the Homeless

Our goal should not be merely to attenuate the “natural” decline of medical-student attitudes toward the homeless. We must enhance and secure the innate interest in the underserved that most students bring to their training. Negative attitudes are most likely attributable to the social stigma of homelessness itself, but they are also an indirect measure of professional maturity and a capacity to be clinically effective in primary care.

Homeless patients, burdened by serious mental illness, substance abuse, multiple-system decompensation, fractured social networks, irregular past treatment, and a mistrust of “the system,” are mostly (but not entirely) “difficult patients.” Clinician frustrations are common and understandable.

Given these inherent treatment frustrations, we have to ask, why is the focus placed solely on labeling the patient as difficult and not at least partly on the physician? Each physician, or human being for that matter, enters situations with his or her own biases, inabilities, and insecurities that can hinder interpersonal effectiveness. A lack of self-efficacy to deal with the consequences perhaps stems from the failure to openly address within the curriculum the skills needed to remediate these intrapersonal issues.

Our call as educators and mentors is to provide the training and role modeling to equip physicians with the mental and emotional skills to serve patients and deal with their own reactions. Through the examination of attitudes using the HPATHI, we have reached the conclusion that, in addition to clinical experiences, there should be a curriculum of specific skills that address counter-transference and other common challenges. It is important that students have a tangible learning experience. That experience, however, must help inculcate in the student the self-awareness and accountability that successful and caring physicians acquire with experience and maturity.

Conclusion

As educators, we must change the way physicians and other health care professionals are taught. We must design substantial and effective ways of transmitting professional, empathic, and culturally sensitive attitudes that will improve relationships with estranged patient populations. We must remove the barriers to care that negative perceptions create and promote active advocacy. Students need more exposure to the economic, behavioral, social, and environmental determinants of health. Research has shown that these dynamics are best learned through an experienced-based curriculum within a positive, supportive, and rewarding environment and that these can eventually outweigh the negative experiences so common in the current system. Making students better able to serve the “difficult” patient will make them better physicians.

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Dedication

To colleague and friend William E. Fann, MD, the finest physician with whom we have worked.

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JOURNAL DISCUSSION

Preferences for End-of-Life Care: A Physician and Homeless Patient Comparison

Carolyn Bramante and John Song, MD, MPH, MAT

Norris WM, Nielsen EL, Engelberg RA, Curtis JR. Treatment preferences for resuscitation and critical care among homeless persons. *Chest*. 2005;127(6):2180-2187.

The 2005 *Chest* article, “Treatment Preferences for Resuscitation and Critical Care Among Homeless Persons,” identified differences between physician and patient desires regarding end-of-life care, specifically mechanical ventilation and cardiopulmonary resuscitation (CPR) [1]. Norris and co-authors compared the preferences of different groups of homeless men and women to each other, to physicians, and to a group of patients with chronic obstructive pulmonary disease (COPD) who were not homeless. This last group was included to control for the difference in education level between the homeless and physician groups. The study found that each group of homeless individuals preferred more care than either the COPD patients or physicians would have chosen for themselves. This is significant because, when physicians treat patients who have no advance directives or surrogate decision makers, they tend to choose for those patients the level of care they would want for themselves [1]. Thus, Norris’s article suggests that when physicians make end-of-life decisions for a homeless patient, they are likely to choose less care than the patient desires.

Homeless individuals face a greater burden of morbidity and mortality and have a life expectancy much lower than members of the general population [2-6]. For example, the average life expectancy in the U.S. is 77.8 years, but the average life expectancy of homeless people can be as low as 41 years, with mortality rates (deaths per 1,000 individuals per year) as high as 10 times greater than the general population [2, 4-7]. Physicians are likely to encounter a disproportionately high number of situations involving end-of-life decisions for homeless patients, and thus there is an urgent need to address the question of how to properly meet the desires of homeless patients [4-7].

The need is also urgent because there is consistent evidence of poor attitudes toward homeless persons [2, 8-12]. This author has heard that “doctors don’t treat homeless people well,” in informal conversations with homeless people. Poor awareness of these patients’ needs and wants is significant because, as Norris and others have reported, homeless patients are less likely to have a surrogate decision maker or a family member who can be reached [2, 3]. Thus, difficult end-of-life decisions may

fall upon physicians, and it is possible they would make choices that they themselves would prefer in such a situation [2, 3, 8].

The authors offer several solutions to resolve the difference in patient and physician desires, such as the use of ethics committees. “We believe these data suggest that institutions should consider developing explicit policy for involving additional persons, such as hospital ethics committees and/or advocates for homeless persons” [13]. They also suggest “asking every patient at the time of hospital admission who their surrogate decision maker would be and how to contact that person” [13]. Both suggestions would help honor the wishes of homeless patients—an important step in fighting for the rights of those who have had little access to health care.

Norris et al. noted several limitations to their study. The participants represent a convenience sample from a limited geographical area with a variety of relationships with family, and the control group of COPD patients was not matched to the other groups. This last limitation is significant because the COPD patients in the control group suffered from significant disease. Their experiences with poor health and the health care system might have influenced their desire for less end-of-life care. A more valuable comparison might be made between a random sample of homeless individuals and a random sample of domiciled individuals in similar states of health.

Norris’s mention of advance care planning and advance directives as the most effective ways to honor the end-of-life wishes of homeless individuals is important. Power over what happens to a homeless person’s body at the end of life is significant for the individual who experienced so little power over much of his or her life [2, 3]. Rather than doing this upon admission to the hospital, however, when levels of stress might be overwhelming or the patient might not have decisional capacity—a distinct possibility given the fact that homeless persons tend to seek medical care later in the course of their illnesses, or if there are overlying mental health or substance abuse issues—health care professionals should strive to have such directives on-record for homeless people in their county [14]. Record keeping would also greatly reduce the burden on physicians and other health care professionals, as well as the strain on bioethics committee consultations.

Is there a danger that this approach might include advance directives that would require medically futile intervention? Might clinicians be forced by these directives to provide care they might not ordinarily provide? This potential is interesting and possible inasmuch as today’s medical technology allows for unnatural longevity at the end of life. This argument cuts both ways, however; physicians might feel more comfortable allowing a natural death if there were a living will indicating that heroic measures were not desired. It is well-established that physicians and medical staff are often reluctant to remove life-sustaining treatments in the absence of an advance directive [14].

Are advance directives the best way to meet the desires of homeless individuals? Would the process of engaging in advance-care planning prompt an individual to

make healthier decisions and engage in less risky behavior? Homeless persons often have extensive experience with death at all ages [2, 3]. Researchers have found that homeless people are interested in having advance directives on-record, and appreciate the chance to talk about these issues with willing listeners [15]. There are conceptual reasons to believe advance directives might better serve a population that is often alienated and estranged from potential surrogate decision makers [16, 17]. These data lend credit to Norris's conclusion that physicians should be made aware that "as a group, homeless persons prefer more aggressive life-sustaining treatments than physicians and some other patient populations" [4].

Because of these limitations and the inherent limitations of generalizing care to a group, it seems that a valuable answer for possible differences in end-of-life wishes is to have a record of advance directives. In fact, shouldn't all patients have advance directives on file, as well as access to the medical resources to honor them? This would help respect wishes of patients, relieve physicians from the pressure of such decisions, and potentially reduce unnecessary waste in medical care.

The article does not address the perhaps unanswerable underlying reasons behind this discrepancy in end-of-life wishes. One possible contributing factor is that African Americans are less likely to forgo life-sustaining treatment. The sample of homeless patients that Norris et al. reported was 47.7 percent African American [18], and white homeless persons often chose answers that correlated closer to the physicians than to their nonwhite counterparts (e.g., CPR in dementia). Another explanation might be that, as groups, physicians and patients judge quality of life differently [19-21]. But that's another research question.

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CLINICAL PEARL

Diagnosing and Treating Schizophrenia

Patrick Aquino, MD

Schizophrenia is a devastating illness with an early adulthood onset and persistent course. The illness affects all aspects of cognition, emotion, perception, and behavior in ways that impact the individual with the illness, his or her family, and society. Schizophrenia is a global disease, affecting 1 percent of the population worldwide [1]. In the United States, an estimated 3 million men and women (in equal numbers) have schizophrenia [2], and unfortunately, only half receive treatment [3]. Despite its relatively small numbers, the economic impact is significant [1]. History has offered many explanations for the genesis of schizophrenia; current research suggests that it is a multifactorial disease based in genetics, susceptibilities, and environment. Diagnosis is made on clinical information alone; there are no lab tests or imaging studies that confirm the diagnosis. Nearly 6 percent of those with serious mental illness, including schizophrenia, are homeless—roughly 200,000 Americans [4].

Diagnosis

The *Diagnostic and Statistical Manual IV-TR* establishes the clinical criteria for schizophrenia, with the foremost information concerning Criterion A [5]. Two or more signs and symptoms from Criterion A must be present for a significant portion of time during a 1-month period (or less if successfully treated): (1) delusions, (2) hallucinations, (3) disorganized speech, e.g., frequent derailment or incoherence, (4) grossly disorganized or catatonic behavior, or (5) negative symptoms, i.e., affective flattening, alogia, or avolition. Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a single-voice running commentary on the person's behavior or thought, or two or more voices conversing with each other.

Though not necessarily for diagnostic purposes, hallucinations and delusions are most associated with schizophrenia. Hallucinations are disturbances in sensory perceptions not based in reality. They occur in any sensory modality, but most are auditory. Visual hallucinations can also be common. When tactile, gustatory, or olfactory hallucinations are observed, clinicians should consider investigating an organic etiology. Delusions are fixed, false beliefs.

The negative signs or disorganized speech and behavior are apparent to the examining clinician, whereas delusions and hallucinations are internal phenomena that can be discovered only by asking. Occasionally, patients respond to internal stimuli by looking around the room when no one is present, carrying on a conversation alone, or behaving or interacting as if someone or something else is

present. Clinicians who observe these behaviors confirm their clinical suspicion by follow-up inquiry. Medical students and residents are taught that the key to establishing rapport is empathizing with patients. But how does a person build rapport with someone whose speech is incomprehensible, who avoids eye contact, and who will not or cannot move? It's easy to see how these patients are quickly labeled as "difficult" or "crazy," euphemisms for unimportant. Yet they are some of our most sick patients.

Historical and collateral data are essential to the diagnosis. It is important to confirm that the symptoms represent schizophrenia, since all psychosis is not schizophrenia. People with several other major mental illnesses, including major depression and bipolar disorder, can exhibit symptoms similar to those of schizophrenia. In these individuals, however, the mood symptoms of depression or mania are more prominent. Several classes of substances including hallucinogens, amphetamines, and stimulants can cause intoxication syndromes that mimic schizophrenia, but the duration of symptoms should be limited by the pharmacology of the drug.

Treatment

Treatment of schizophrenia is fundamentally similar to the treatment of other chronic diseases. The lifelong presence of symptoms and deteriorating course requires maintenance as well as symptomatic treatment of exacerbations. In most instances collaboration with a psychiatrist is necessary. There are a number of pharmacologic options available for the treatment of psychotic symptoms—typically categorized as first-generation (FGA) or typical antipsychotics and second-generation (SGA) or atypical antipsychotics. Both types block dopamine receptors, though relative ratios or receptor targets may be different. Several studies have demonstrated the efficacy of all of these medications [6, 7]. The same data demonstrate that SGAs are not necessarily better than FGAs; but they are additional medications in an ever-expanding armamentarium of treatments. Choice of medication should be guided by history of positive effects in the individual patient, side effects, and individual choice. A risk-benefit discussion should be conducted with the patient, since all medications carry risks.

The FGAs (e.g., haloperidol, chlorpromazine, perphenazine) impose higher risks of extra-pyramidal side effects (EPS)—dyskinesia, akathisia or parkinsonian-like movements—associated with increasing amounts of dopamine blockade. The side effects must be weighed against the clinical benefit. EPS can be managed with dose reduction, change in antipsychotic, or anticholinergic medication. Tardive dyskinesia (TD) is a serious side effect characterized by the delayed onset (tardive) of irregular, involuntary choreoathetoid movements of the face, trunk, or extremities. The risk of developing TD is approximately 3 to 5 percent per year of exposure to FGAs [8] and treatment is difficult after onset, so it must be considered in the risk-benefit calculations at the start of treatment.

The SGAs (e.g., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, clozapine) carry a lower risk of EPS and are thought to not worsen the negative

symptoms of schizophrenia. These drugs are effective for the psychotic symptoms with fewer risks of EPS and TD [8]. But the risks of developing metabolic syndrome, hypertension, dyslipidemia, or glucose intolerance are significant [9, 10]. Neuroleptic malignant syndrome, characterized by fever, rigidity, confusion, and autonomic instability, is a life-threatening side effect of all antipsychotic medications. This is a medical emergency and requires supportive care, discontinuing antipsychotics, and possibly other interventions [11]. Again, careful consideration of the risks and benefits is essential to choosing treatment.

Pharmacologic intervention is only one facet of the treatment. Although difficult to accomplish during the acute stages of the disease, education and understanding of the disease are necessary to keep an individual connected to caregivers for management. The vast majority of schizophrenic patients have caring families and support systems. As nonpharmacologic treatment of schizophrenia moves from the hospital to community, progress of those with the illness improves. Managing their psychosis is only the beginning. Once that is accomplished, we depend on organizations to help those with schizophrenia engage in the pursuits we all strive for—work, relationships, and meaning.

Comorbidities and Screening

After diagnosing schizophrenia, it is important to screen for other somatic conditions, particularly because of the significant metabolic side effects of antipsychotics. Medical illnesses occur in three-quarters or more of those with severe mental illness, including schizophrenia [12]. Unfortunately, medical illnesses often go undiagnosed, resulting in higher mortality rates and mounting survival gaps with a potential of 13 to 30 years of life lost [13]. Larger studies, including the CATIE schizophrenia trial, indicate higher rates of diabetes, hypertension, cardiac, pulmonary, hepatic, and infectious diseases including hepatitis and HIV [6, 14, 15]. Individuals with severe and persistent mental illness are less likely to receive full medical services for chronic diseases like diabetes or to have cardiac revascularization in coronary artery disease [16, 17]. Though they do not necessarily have higher rates of cancer than the general population, people with mental illness are more likely to die of cancer, possibly because of deficiencies in screening and treatment [18].

Those with schizophrenia have an increased likelihood to have comorbid substance-use disorders (not including nicotine), so screening is important. Several quick screening tools can be administered during any clinic visit [3, 19, 20]. The risks associated with tobacco use are well-recognized. Ninety percent of individuals with schizophrenia smoke cigarettes and when they do, they generally smoke more cigarettes with greater frequency and increased levels of tar [21, 22]. Pharmacologically, smoking also decreases amounts of active antipsychotics [23]. Treating schizophrenia requires a multimodal approach aimed at psychiatric, somatic, and addiction symptoms.

Like many chronic illnesses, early recognition of schizophrenia can yield beneficial results. Identification in the primary care clinic or emergency department should result in a referral or consultation with psychiatric care to facilitate treatment. Early intervention can establish solid, encompassing care and help patients limit the revolving door of service utilization. As with many other chronic illnesses, treatment of schizophrenia requires a team approach of physicians, family, and community. With aggressive and progressive treatment and compassion we can help these individuals cope with their illness and attain their potential.

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HEALTH LAW

Refusal of Emergency Care and Patient Dumping

Jeffrey Kahntroff and Rochelle Watson

Gabino Olvera is a 42-year-old man who is mentally ill, paraplegic, and homeless. He was dropped off by Hollywood Presbyterian Medical Center in a soiled hospital gown with a catheter bag and no wheelchair in a neighborhood populated by many other homeless people [1]. Carol Ann Reyes, an elderly woman suffering from dementia, was dropped off by Kaiser Permanente Bellflower Medical Center in front of Union Rescue Mission, an organization that serves the needy and homeless, wearing just a hospital gown [1]. This practice is known as “patient dumping.”

Patient dumping violates the federal Emergency Medical Treatment and Active Labor Act (EMTALA). Enacted in 1986, EMTALA seeks to prevent any refusal of care for patients who are unable to pay [2]. It imposes three requirements on any Medicare-participating hospital and enforces monetary sanctions against physicians or hospitals that do not comply [3]. Participating hospitals must: (1) conduct medical-screening examinations, (2) provide necessary stabilizing treatment to any patient seeking emergency medical care in an emergency department, and (3) hospitals that are unable to do (1) and (2) may transfer the patient to a facility that can provide those services in a manner that accords with EMTALA guidelines [4].

To establish a violation of EMTALA, “a plaintiff must demonstrate that (1) the hospital is a Medicare-participating hospital covered by EMTALA that operates an emergency department (or an equivalent treatment facility); (2) the patient arrived at the facility seeking treatment; and (3) the hospital either (a) did not afford the patient an appropriate screening to determine whether he or she had an emergency medical condition, or (b) bade farewell to the patient (whether by turning away, discharging, or improvidently transferring him or her) without first stabilizing the emergency medical condition” [5]. Forty-three of the 50 states have adopted statutes similar to the federal requirements [6-9].

Despite these statutes and penalties, hospitals have continued turning patients away. From 1996 to 2000, the watchdog organization Public Citizen confirmed violations from 527 hospitals in 46 states, as well as the District of Columbia and Puerto Rico [10]. Of the 527 hospitals, 117 had violated the act more than once, and for-profit hospitals were significantly more likely to do so [10].

EMTALA’s inability to curb denial of treatment has been attributed to the ambiguity of the statutory provisions, poor enforcement mechanisms, and divergent judicial interpretations of the statutory provisions. A 2001 Office of the Inspector General (OIG) study revealed that emergency-care personnel and hospital staff are often

unaware of EMTALA provisions and policy changes, and, even when they are aware, there is uncertainty about the proper interpretation and application of the provisions [11]. Furthermore, most emergency personnel do not receive EMTALA guidelines [11].

Lack of uniformity in enforcing the provisions also contributes to their ineffectiveness. Some hospitals have a greater chance of being investigated than others, not because they are more prone to violate EMTALA terms, but because they are geographically closer to Centers for Medicare & Medicaid Services (CMS) regional offices [11]. The EMTALA enforcement process fails to notify hospitals that are at risk for violating the proper standard of care, and regional CMS offices often don't inform state survey agencies, hospitals, and peer-review organizations about their decisions [11]. Thus, statistics on violations are often inconsistent and incomplete.

Judicial decisions have also produced conflicting interpretations of what emergency personnel must do to comply with EMTALA. The EMTALA requirement that emergency personnel provide appropriate medical screening within the capability of the emergency department, for example, can be interpreted under an objectively reasonable standard, subjective standard, or burden-shifting standard [12-14]. There is discrepancy about whether physicians should be held to the negligence standard of care customary in the medical field, or whether EMTALA is governed by a strict liability standard [15]. Finally, disagreement persists over whether the three duties imposed on medical personnel—to provide an appropriate medical screening examination, to stabilize, and to appropriately transfer patients—are separate duties that should be considered individual causes of action under law or whether they should be viewed conjunctively [16, 17]. The divergent standards of judicial interpretation further hamper EMTALA's effectiveness by creating inconsistent standards of compliance. Emergency personnel are not able to comply with EMTALA provisions because it is not clear what exactly is required of them, and case law has only exacerbated the problem.

Despite EMTALA's shortcomings, the statute is not without bite. The OIG recorded eight violations of EMTALA in November 2008 [18]. Baptist Hospital, Inc., in Florida, agreed to pay \$22,500 to settle allegations that it failed to perform a medical screening on a suicidal man. After informing the registrar that his suicidal thoughts were growing stronger, the patient was informed that he would have to continue to wait—he then proceeded outside and lacerated his right arm [18]. Cumberland County Hospital System, Inc., in North Carolina, agreed to pay \$42,500 to settle claims that it unsuccessfully provided appropriate medical screening or stabilized a suicidal 13-year-old girl. The physician saw the patient for 5 minutes before releasing her. Fifty minutes later, the patient jumped out of a car traveling approximately 40 miles per hour and fractured her skull [18].

Recent cases in Los Angeles demonstrate that the threat of large fines might deter the practice of patient dumping under state law. The Los Angeles City attorney secured a

settlement with Methodist Hospital amid allegations of patient dumping that required the hospital to implement detailed protocols for the discharge of homeless patients. The hospital will also contribute \$215,000 to fund recuperative care beds for homeless individuals at the Salvation Army's Bell Shelter and pay \$5,000 in civil penalties and \$20,000 in investigative costs [19]. Kaiser Hospital reached a similar agreement in May 2007, resulting in court-ordered protocols for the proper discharge of homeless patients, as well as \$500,000 in donations to a charitable foundation that offers services to the homeless and \$5,000 in civil penalties [19].

In response to recent incidents in California, Los Angeles passed a city ordinance that prohibits transporting or arranging for the transport of patients to somewhere other than their home without their written consent [20]. A violation of the ordinance warrants a \$25,000 penalty for the misdemeanor and the suspension of the hospital's Medicare finding for at least 5 years [20].

The underfunded health care system in the United States drives the practices of patient dumping and refusal of care. Caring for patients who do not have insurance is costly, and much of the treatment often goes without reimbursement. From 1994 to 2005, the number of emergency department visits increased 18 percent from 93.4 million to 110.2 million annually, a rate that coincided with the rising costs of care and lower reimbursement by managed-care organizations and other payers, including Medicare and Medicaid [21]. The trend disproportionately affects low-income patients, who generally do not have access to health care and often seek it in emergency rooms. In response to the rising costs of medical care, states have implemented a series of measures directed at lowering costs, including reductions in Medicaid eligibility, benefits, and provider payments [22]. As Clay Mickel, spokesman for the American Hospital Association, stated, "The real problem is that the government has not acknowledged that caring for the indigent is its responsibility" [23]. The solution to patient dumping may lie in addressing its root causes rather than strengthening the enforcement mechanisms in EMTALA and similar state statutes.

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POLICY FORUM

Enrollment of Economically Disadvantaged Participants in Clinical Research

Neal Dickert, MD, PhD

In 1996, the *Wall Street Journal* ran the following headline: “To screen new drugs for safety, Lilly pays homeless alcoholics” [1]. The article provoked reactions of outrage and disgust. How could researchers use society’s most disadvantaged people as guinea pigs to develop drugs that these participants could never afford? Even worse, how could they entice them with offers of money or health care, preying on the very vulnerabilities that are so disconcerting?

These reactions are understandable, and there may indeed be something wrong with how we enroll homeless and other disadvantaged populations in clinical research. The source of the problem, however, may not be that homeless people with alcoholism are disadvantaged or that incentives are used to recruit them. Evaluating this matter responsibly reveals that these gut reactions are often misdirected.

The Risk and Importance of Research

The central ethical challenge in clinical research is that it exposes people to risks that must be justified by benefits to society or science in the form of medical knowledge. Researchers, institutional review boards (IRBs), and sponsors of research take great pains to minimize risks. And although the risk of every project differs and is difficult to estimate, approved clinical research is heavily scrutinized and appears to be safe, despite what media reports and participant consent forms may suggest.

Participating in research is definitely safer than high-risk occupations such as firefighting, law enforcement, or military service and almost certainly safer than the majority of construction work, manufacturing jobs, or garbage collection—jobs that are important and legitimate despite known risks. Like these occupations, clinical research produces a valuable social good that justifies placing individuals at some level of risk. That said, tragedies do happen, as exemplified by the case of Nicole Wan, a 19-year-old student who died as a result of a fatal reaction to lidocaine administered during a research bronchoscopy [2].

If we accept the imposition of some risk for societal benefit, we must confront the question of *which people* researchers should expose to it. Despite a tendency to react otherwise, there is no obvious reason to believe that economically disadvantaged people ought not to be exposed to the same levels of research risk as the rest of the population. Provided they participate in studies for which they give a valid informed consent, why for example, should we exclude homeless people [3]? One common view is that the principle of justice dictates that disadvantaged populations ought not

to be exposed to risks when they are not likely to be among those who benefit from the research findings. But this view does not always stand up to scrutiny. We never argue that poor people should not collect garbage in wealthy neighborhoods or that a homeless person should not be employed building expensive houses. Similarly, if I want to participate as a healthy individual in a study designed to improve the understanding of Parkinson's disease, my own likelihood of developing the disease (thus potentially benefitting from the study data) seems irrelevant to whether I should be allowed to enroll.

Some have claimed there is no reason to exclude disadvantaged individuals entirely, but that enrolling a disproportionate number of them is a problem. Several leading scholars, for example, assert that enrolling 1 percent homeless participants is justified, but having 100 percent homeless participants is not (assuming that the study is not focused on a problem unique to the homeless) [3]. "Pattern equity" is the term used to describe the distribution of research risks or burdens and, although there is widespread concern over pattern equity, its importance is unclear [4, 5]. I suspect that enrolling very high numbers of homeless people in a study may indeed indicate that the study has potential problems, but it is difficult to argue that the distribution of research burden is itself unjust if the level of risk posed by the study is indeed acceptable and participants feel they have an opportunity for financial gain or health benefit.

Examining the Study

There is an important caveat to the preceding comments: *clinical research that enrolls disadvantaged people must be ethically acceptable in the first place*. In other words, studies must meet basic standards of ethical acceptability regardless of whom they enroll. As elaborated by Ezekiel Emanuel and colleagues, these standards include: the potential for social value, a scientifically valid methodology, fair participant selection, a favorable risk-benefit ratio (including benefits to society), independent and thorough review, informed consent, and respect for participants [6]. Studies that do not meet these standards should not be approved. Most of the studies cited by Elliott and Abadie as exploitative of disadvantaged populations, for example, are flawed in fundamental ways—either they have not been adequately reviewed, are conducted in unacceptable facilities, or have used compounds that may not have been sufficiently researched [7]. These studies should not be conducted. Ensuring that these basic ethical standards are met may require special measures for certain populations. There may be special challenges regarding informed consent when enrolling homeless participants given the high prevalence of psychiatric disease among this population. Special procedures may be necessary to guarantee that consent is adequate, and exclusion of individual participants is obligatory when this cannot be achieved [3].

It may be that only disadvantaged people without reliable ways to make money or obtain health care will find enrolling in ethically problematic studies attractive. Taking advantage of their vulnerability to circumvent ethical standards of research is fundamentally exploitative and must not be tolerated. Thus, additional safeguards

may be needed to monitor and prevent such exploitation, if unethical research is indeed as endemic as Elliott and Abadie suggest [7]. The problem in many of these cases, however, lies in the research studies and the regulatory system and not in the participant population. What we owe these participants is adequate review and oversight and not exclusion or different ethical standards.

Incentives Are Rarely the Problem

Much of what I have argued thus far may not be controversial. Most people would agree that nobody, homeless or not, should be asked to participate in a study that fails to meet criteria for ethical research, and most recognize that some level of risk is inevitable and justifiable. Still, many feel that offering incentives to induce disadvantaged people to participate in otherwise approvable studies remains problematic. These worries are typically cast as concerns about coercion, undue inducement, or exploitation and are largely overstated and misunderstood [7].

To start, coercion is never acceptable in research. Fortunately, true coercion is incredibly rare in research, and no offer of money or health care can coerce anyone unless there is some threat of harm for refusing [5, 8-11]. For a situation to be defined as coercive, a potential participant must be made worse off for refusing to participate than if he or she had never been presented with the option in the first place. For example, it would be coercive to strong-arm a homeless man into participating in a study by threatening to report criminal behavior to his shelter if he does not agree to take part. It would not be coercive, however, to offer him a large amount of money to participate. The money may be very attractive to him, and he will almost certainly agree to participate. But this situation is not coercive because the man would not be worse off for refusing the offer than if he had never been asked.

The more appropriate and complicated concern is that disadvantaged participants may be unduly induced by large amounts of money or health benefits. What counts as “undue inducement” is debated, but most discussion of this issue focuses on the potential for attractive incentives to: (1) undermine participants’ ability to give valid informed consent by either compromising the voluntariness of their decisions or causing them to ignore and remain uninformed about study risks, (2) cause people to exercise poor judgment, or (3) lead participants to hide pre-existing conditions, side effects, or other information that might make them ineligible for inclusion [5]. Emanuel, in a provocative and important series of papers, argues that concern for undue inducement is “nonsense on stilts” [12, 13]. There are no data to suggest that people misestimate risks because of payment. Some paid participants have said they care less about risks when the amount of payment is high; others have said they are actually more attuned to risks when payment is high [14, 15]. Even if offers did cause people to underestimate risk, the most appropriate initial solution would be to alter consent practices rather than reduce incentives. More importantly, it is far from clear why decisions made for monetary gain in research would compromise voluntariness when they do not in other contexts. How many of us would want a

potential employer to reduce a salary offer in order to make sure our decision to take a job is voluntary?

As Emanuel argues, it is also not clear how enrollment in an appropriately approved study would represent poor judgment. After all, IRBs should only approve studies in which they believe it would be reasonable (and thus not poor judgment) for eligible people to enroll. If enrolling reflects poor judgment, the IRB should not have approved the study, regardless of how much payment is offered [13].

Finally, no good data exist on the extent to which potential participants lie or hide conditions in order to maintain eligibility, though it certainly has occurred. Bernadette Gilchrist, for example, was an NIH nurse who died in a paid sleep-deprivation study most likely as a result of electrolyte abnormalities secondary to bulimia, a condition she failed to disclose to researchers presumably because she thought it would disqualify her from participating [16]. Although there are potential data integrity implications when participants fail to report important information, researchers' responsibilities can only go so far in protecting people from risks that derive from their own intentional misrepresentation of their health.

Undue inducement concerns are largely overestimated, and there is a need for more data on the extent to which they are borne out in practice. I do, however, believe that this concern is relevant when considering incentives to severely disadvantaged people, but only at the end of the spectrum of approvable risk or when research involves asking people to trade off values they hold important. I suggest that real undue inducement occurs when large offers induce people to make choices—that may be entirely informed and voluntary—to do activities to which they have strong objections based on their own values [5]. Examples include a homeless person with deep risk aversion who is induced to participate in a very risky (but approvable) study or a homeless Jehovah's Witness induced to participate in a trial involving a blood transfusion. Because research institutions should not be in the business of making "indecent proposals," the concern for undue inducement gives us reason to avoid dramatic escalations of payment at the risky end of approvable research and when recruiting from populations known to have significant aversion to specific studies. But values vary greatly. IRBs cannot, and should not attempt to account for the values of all potential populations—otherwise no study would be approvable. As a result, some undue inducement is unavoidable and not the responsibility of researchers or IRBs to prevent entirely.

A crucial reason for avoiding overreaction to the potential for undue inducement is the opposite concern—exploiting severely disadvantaged populations by not paying them enough [7]. Just as disadvantaged people are vulnerable to inducements, they are vulnerable to being taken advantage of by offers that undervalue the service they perform. Consider a phase I study of a new antibiotic in healthy people that involves a several-day inpatient stay, drug infusion, and multiple blood draws. If that study offered participants \$50 a day (\$150 total), who would participate? Most would expect to be better paid for such a burdensome study. Providing very low payments

knowing that there are people poor enough to find this offer attractive is paradigmatic of exploiting their situation in a morally problematic way [5, 7]. Lest this concern seem illegitimate, several interview studies of paid participants—many of whom are poor—illustrate that those participants are more worried about being paid too little than about being paid too much [15-17].

The difficulty of balancing concern for undue inducement against concern for exploitation is one reason to adopt an approach that pays participants based on the nature of the unskilled but valuable work they perform [5]. A relatively consistent and standardized payment strategy that pays participants according to the prevalent wage for similar jobs and allows adjustments for inconvenience, discomfort, and, to some extent, risk, will protect them from undue inducement, largely avoid exploitation, and reward people fairly for the valuable service they perform. This strategy will result in a high number of disadvantaged people participating in research, but there is no reason to exclude them as participants, and it is not clear that the pattern-equity concern is sufficient to make this problem a priority. Research studies still must pass stringent ethical muster on all other grounds, and reductions in payment would simply promote exploitation and restrict income from a viable and socially beneficial work option [18].

Conclusion

While disconcerting initially, the enrollment of highly disadvantaged people in paid research studies is generally acceptable on further analysis. Many frequent participants in paid research rightly view it as a valuable and viable work opportunity; denying this opportunity seems both unnecessary and inconsistent with our views of other occupations, many of which involve greater risks and less social value. Studies that enroll disadvantaged populations must be carefully scrutinized to ensure that they meet adequate conditions for ethical research. Similarly, fair payment for participation in acceptable and approvable research is entirely appropriate, and the fact that payment increases participation among poor participants is a relatively small problem. Underpayment, however, in an attempt to protect vulnerable participants, may result in exploitation and fails to recognize that monetary gain is factored into numerous decisions every day.

It is important to recognize the elephant in the room—the driver of many of the gut reactions to enrollment of disadvantaged populations in paid research. Many of these people are the victims of profound injustice and have been abandoned by much of society. The injustice that constricts their options for making ends meet is presumably one of the chief reasons why participation in paid research is attractive. This recognition should strengthen our resolve to ensure that ethical standards of research are met and, more importantly, address the source of injustices in the first place. It does not mean that we should further restrict their options to participate in improving medical knowledge.

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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.

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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.

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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.

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MEDICAL NARRATIVE

When Half a City's Residents May Be Homeless: New Orleans After Katrina
VM interview with Benjamin Springgate, MD, MPH, conducted by Kathleen M. Patchan

Q: What were some of the more notable medical illnesses and mental health issues that Katrina survivors faced?

A: Hurricanes Katrina and Rita impacted health and health care for the people along the Gulf Coast in a number of ways. In the short term, those with serious chronic illnesses—like diabetes mellitus, chronic obstructive pulmonary disease (COPD), and cancer—had significantly diminished access to needed health care and medications for periods ranging from months to years. Health care sites and systems for hundreds of thousands of people were destroyed, including the loss of millions of medical records, hundreds of doctor's offices, and entire hospitals. Thousands of clinicians were displaced, and some—like their patients—were forced to relocate permanently to other areas of the country. Many who faced serious health consequences as a result of interrupted or delayed care were low-income and uninsured people. Because these interruptions prevented some patients from getting medications for transmissible illnesses, antituberculosis or antiretroviral medications, for instance, they threatened the health of the public at large [1, 2].

The most critical and worrisome long-term health problem that emerged from Hurricanes Katrina and Rita has been the enormous effect on the mental health of children and adults alike [3]. Epidemiologic studies have taught us, that, after most disasters, a certain percentage of the affected population experiences new-onset symptoms of depression and/or posttraumatic stress disorder (PTSD). Prevalence usually peaks at around 6 months to 1 year after the disaster and diminishes thereafter as people get treatment or as their natural resilience fosters spontaneous recovery. After Katrina and Rita, symptoms of stress, depression, and PTSD rose dramatically and did not recede. The best data suggest that 35 to 40 percent of people who lived in areas directly affected by the hurricanes continue to experience these disabling symptoms [4]. This is twice the baseline incidence for that region of the country.

One hypothesis for this high prevalence of symptoms is that the enormity of the devastation and inadequacy of assistance following the hurricanes have delayed recovery. In New Orleans more than 3 years later, once-vibrant neighborhoods remain barren and people still struggle to cope and experience ongoing PTSD and depression.

Q: How did the health care system address these illnesses during the disaster and in the ensuing months?

A: During the immediate disaster, volunteers, public agencies including the United States Public Health Service, local hospitals, and health care teams responded quickly with a patchwork of services to assist the millions of people displaced in shelters in other communities, as well as those who were not able to evacuate. Delivery of services was not particularly systematic, but we did not see major outbreaks of infectious disease among the evacuees, and that was a small victory. In the months that followed, Medicaid waivers allowed some coverage for enrollees across state lines so that at least some of the displaced people did not lose benefits and were able to seek care in settings that accept Medicaid. Local health care stakeholders in Louisiana began to work quickly after the hurricanes to rebuild the system. In New Orleans, volunteers and nonprofit organizations organized several new clinics in the weeks that followed, many of which have now become leading sources of care in the community as it rebuilds, particularly for uninsured residents [5].

Q: What are some of the ethical issues you encountered in working with patients made homeless after a natural disaster? How are these different from those of other homeless patients?

A: One has to adopt a somewhat different lens when, instead of facing the challenges of a homeless individual or family, or the collective needs entrenched in a given homeless shelter, one faces the challenges of a community that has lost 100,000 housing units, the homeless population has doubled, and, at least initially, half of the population is at risk of becoming homeless. This prompted many questions. What should my priority as a doctor be? Should standard health care for chronic physical conditions come first, knowing that, because of the destruction of the infrastructure, my patients will be unable to receive basic lab tests with fewer than three referrals to three separate locations? Should I be trying to get patients mental health care, knowing that depression is the second leading cause of disability worldwide and that essentially everyone is at risk of depression? Should I try to help an individual stabilize his or her housing situation, knowing that housing stability plays a major role in determining how successfully one can manage health conditions? Given the breadth of the needs and the limits of resources, prioritizing interventions raises a host of ethical issues. Preventive care has often fallen by the wayside entirely, because now, in the entire community, there is literally nowhere for an uninsured person to receive preventive procedures such as a screening colonoscopy.

Q: What are some of the efforts being made by physicians, health care facilities, and the Louisiana Health Care Redesign to improve care for the homeless?

A: The extent of the infrastructure needs in some parts of the community are so broad that most organizations and providers do not pay attention to care for the homeless per se, except as a byproduct of intervening to affect care for the greater

population. For instance, the main source of care for low-income and uninsured people including the homeless in New Orleans until the disaster was Charity Hospital and its affiliated clinics. After flooding caused by the levee failures, Charity closed, though some of its services have reopened nearby. There have been multiple proposals to rebuild Charity on a new campus, most likely alongside a new Veterans Administration Hospital. These new hospitals would help many homeless people, though it will probably be many years before these proposed hospitals open their doors. Meanwhile, without an overhaul of the payment systems and expansion of coverage through Medicaid, homeless and low-income individuals without insurance will continue to live without certain hospital-based services. New clinics such as the Tulane Community Health Center at Covenant House, mobile health units like the Tulane and St. Anna Mobile Medical Units, and volunteer-supported efforts like the Common Ground Health Clinic have made strides to improve access to ambulatory care for the homeless, but there is still room to grow.

Q: Do you foresee a physician shortage continuing in those areas affected by Katrina?

Fortunately, state and federal support in the form of medical school loan repayment and other incentives have closed the health care professional shortage so that, on a per capita basis, New Orleans now has enough doctors overall, though shortages remain in specialty areas like psychiatry. The challenge from a public health perspective is that most doctors work in settings that are inaccessible to the uninsured, so the distribution of those services is misaligned.

Q: What are some important things that medical students need to consider when working with underserved communities?

A: Most importantly, medical students should keep in mind that it is a privilege to care for the patients and communities with whom they work. Practice humility, and when you think you have practiced enough, practice humility even more. You, the student, are walking away with a lot of education and potential for growth because of the privilege your patients grant you with each encounter. As a student and doctor, we do not bring any more value to the encounter than the patient does. You must engage the patient and community as your partners if you are to make a lasting difference and share the benefit of your experiences and training. If you are to benefit from their lives and experiences, you must earn their trust.

Q: How has your work with Katrina survivors changed your view of medicine? What do you think are important lessons that Katrina can teach medical students and residents?

A: I think Katrina showed all of us that the entire nation is far more vulnerable to disasters than we might have expected and that we are more resilient in our ability to work together to facilitate recovery. The amazing stories we have heard since the hurricanes—new clinics opening, people receiving needed care, delivery of

emergency services—are attributable to the efforts of residents and students at Tulane, LSU, and Ochsner, and to volunteers and community members who worked an incredible number of hours to help keep the city and its people alive.

Q: What do you think can be done by the medical profession, as a whole, to improve care to underserved populations?

A: As physicians we must seek to improve health care for those who suffer from the greatest health disparities. In the United States, this means particularly members of racial and ethnic minority groups. Physicians must acknowledge and respond to the staggering and enormous evidence base about disparities and how to reduce them. People of many backgrounds experienced adverse life changes and poor health consequences as a result of the 2005 hurricanes and levee failures, but, overall, the health and other impacts of the disaster were born disproportionately by African Americans. If our goal is to improve health, we must also strive to improve health equity.

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MEDICAL NARRATIVE

Boston HealthCare for the Homeless Program: A Success Story

James O'Connell, MD

In the final year of my internal medicine residency at Massachusetts General Hospital (MGH), the chief of medicine, Dr. John Potts, called me into his office following rounds. He and Dr. Tom Durant, who was well-known and admired throughout the hospital, presented me with a...“request.” They had been involved in a citywide coalition that had funds to take care of homeless people. The coalition of community and homeless people were adamant that they needed a full-time paid doctor (rather than a volunteer) to work with the nurses, but they had been unable to find one. Drs. Potts and Durant had decided that the physician should be MGH's contribution to program, and they were trying to find a doctor willing to do it. They zeroed in on me, arguing that it would be something good to do for a year, like urban Peace Corps. Having graduated from college in the late 1960s, I had a consciousness hangover and thought it would be a great job to take for a year. Dr. Potts agreed to defer my fellowship in oncology for a year, so it wasn't as though I was giving it up, just delaying it.

The grant funding from the Robert Wood Johnson Foundation established our Boston HealthCare for the Homeless Program (BHCHP), and it has been my full-time job for the past 23 years. I am also an attending physician for MGH, and BHCHP has had a daily clinic at MGH since 1985. Whereas most clinicians volunteer to help poor, indigent, or homeless patients, I am blessed to be paid to do work that I love.

Illness Exacerbated by Homelessness

I think everyone who works with homeless people finds that it is complicated medicine. One of the first discoveries you make is that people have chronic illnesses that have been neglected for a long time—hernias have been ignored for many years, hypertension has been out of control and unknown for many years, diabetes not yet diagnosed or treated. When I first started, HIV was beginning to affect the homeless population also. I had loved practicing medicine at an academic teaching center, so I was surprised by how consuming and rewarding my new practice was.

Not long after discovering the chronic illnesses homeless patients have, I became fascinated by the social determinants of health and illness. When caring for someone with no home, no place to go, and nowhere to store medications, the obstacles to treatment can be overwhelming. You are galvanized to take action to reduce those obstacles and change social policy for people who are so vulnerable. But failed policy is, in fact, failure in so many sectors of our society—education, corrections,

health care, and social services. Inadequacies in each of these areas have allowed homeless people to fall through the cracks. Fixing the problem is a big job, and one doctor is just one small voice.

I've watched many doctors and nurses become discouraged at this point—wanting to take care of someone but feeling they are swimming uphill. Then, after 6 months or so, you realize that your patients are amazing people with stories of unbelievable courage who are dealing with circumstances you can barely imagine—and who are depending on you to be their doctor. This is when the job starts to grab you. Utterly and quietly I realized that I was attached to the people I was caring for and that I wasn't going to be practicing oncology in an academic hospital any more. I would take care of my patients' suffering today and do what I could to alleviate its social sources where possible.

The common illnesses of homeless people are often magnified by their circumstances. In diabetes, for example, which is so common in medicine and primary care, exercise and diet control are standard management approaches. People living in the shelter have no way to control their diabetes because the meals given to them are typically high in calories and carbohydrates. If insulin is needed, many of the shelters in Boston do not allow needles inside the building. We've had to design therapies for diabetes that respect the situations people are living in. This is an example of a common illness that becomes far more complicated to treat when homelessness is in the mix.

Tuberculosis is another example. One of our shelters had an outbreak of 100 active cases of pulmonary TB. When that occurred, I suddenly realized that I was in public health medicine where the care of one person had a direct effect on the care of the others living in the shelter.

In 1985 we saw the first case of HIV or AIDS in the shelter. By the end of the first year, we had 100 cases, and the numbers were escalating. In those days there was no effective medication. We didn't really know what the virus was and could only treat the complications. It was a losing battle; almost everyone died. That management of the illness was so difficult just made us want to work harder.

We see pellagra and vitamin deficiencies such as scurvy in our patients that are rare in populations that have regular access to good food and nutrition. But the conditions most emblematic of homelessness are frostbite and hypothermia. Most of the care of frostbite occurs at home and not in the hospital. But every winter we treat many people with frostbite of their fingers and toes, while the long process of auto-amputation continues. With my patients' permission I have taken pictures to show medical students and other doctors what this horrifying process looks like. I'm embarrassed to admit that I am expert in the care of frostbite—embarrassed because it's a completely avoidable condition that results in loss of digits and parts of the body. It occurs every winter in most of our big cities in the Northeast and probably in the rest of the country.

The Success of the Boston HealthCare for the Homeless Program

BHCHP was put together by a coalition of homeless people, community activists, and shelter providers who were suspicious of the medical community. When the grant came to Boston, they feared that the doctors would decide what they wanted to do and just do it. The coalition wanted to have a full stake in what was going on, and they embraced the concept that health care was a matter of social justice, not charity. The coalition members did not want to use volunteers because they wanted continuity of care delivered by full-time doctors who would be available to see their patients the same way we expect our primary care doctors to be available for us. They also insisted that we set up a system that was not separate from mainstream health care. The full-time doctors who saw homeless people in the shelter and streets were to be part of the hospital. When I go to take care of someone under a bridge, I'm an MGH doctor and that patient is an MGH patient. I think the insistence of the community on this point has allowed us to grow in a way that none of us predicted.

I fought against the plan for a while because it meant, for one thing, that we couldn't use medical students. In the view of coalition members, allowing medical students to care for homeless people was tantamount to experimenting on our patients. They made sure that we set up a system in which full-time clinicians worked in teams with doctors, nurse practitioners, physician assistants, nurses, and social workers so that a continuous infrastructure was in place. And finally, they said nothing changes unless health professionals learn to create one-on-one relationships with patients. The thrust of the program was getting clinicians out of the traditional clinical sites to places where they could meet homeless people, get to know them, and parlay that relationship into good primary and preventive care. In retrospect, their demands were brilliant. I am so glad that I wasn't the one establishing the program; I would have built something totally different.

We now have 17 doctors, 35 nurse practitioners, and 60 nurses, most of whom are full-time. We have three hospital clinics and 75 clinics in shelters and community sites familiar to homeless people. We have a street team and a racetrack team, and we pretty much get ourselves to wherever homeless people are. Everyone is on the same electronic record, and all of the people we see outside are automatically patients of Boston Medical Center or MGH once we see them.

Lastly and importantly, we have a respite care program, the McInnis House, named after Barbara McInnis, a nurse who was our inspiration. In 1985 people who stayed in shelters had to leave early in the morning and could not come back until late afternoon. Homeless advocates pointed out that when people are sick with the flu or suffering from back pain, it's hard to go to the streets and walk around until 4:30 in the afternoon. They gave us the task of designating a portion of the shelter for beds so that people who were sick had a place to stay during the day.

When we started the respite program in 1985, Dr. Janelle Goetcheus (who founded Christ House) and David Hilfiker (who later founded Joseph's House) were involved

in similar efforts in Washington, D.C. In those days, people who had coronary artery bypass grafts (CABG) stayed in the hospital for 1 month to 5 weeks. Today a patient stays an average of 3.6 days after CABG. The acuity of “home” care escalated as lengths of hospital stay declined, and demands on our program grew. We had to keep adjusting to meet that new level of care. Many surgical procedures that were once done in the hospital are now performed as day surgery. For homeless people who have no place to recover or receive pre- and post-operative care, our respite programs fill that gap. We bring people in the day before, transfer them to the hospital for surgery, pick them up afterward, and bring them back to respite care.

In 1992 we bought an old nursing home to accommodate the growing need for respite care, and we have gradually expanded from 52 beds to 72 beds to 90 beds. In 2008 we moved into a newly renovated building and expanded to 104 beds. The respite program has given us a unique place within the medical community in Boston. Every hospital sends people from the wards into the McInnis House for continuing care or from the emergency room when they don’t want to admit someone but are afraid to send him or her out. When I see someone on the street who is in danger of developing frostbite, I am able to admit that person to McInnis for 24-hour medical and nursing care. McInnis House has become a national leader in the development and evolution of medical respite care for vulnerable homeless people and has helped us to integrate medical, mental, and oral health care of homeless persons.

Educating Medical Students to Care for Homeless People

When I was training at Harvard from 1978 to 1982, one had to be really creative to find opportunities for community service. In the past 10 to 20 years, medical schools have done a remarkable job in reaching out to their communities. Time available to spend in the community during medical school is limited, and it can be even more limited during residency. The key is to make service a part of the curriculum and an acknowledged activity that is expected of future physicians and medical students. We still have a long way to go, but things have certainly changed for the better.

Some students who come to BHCHP don’t feel comfortable in the shelter, but are fully at ease in other settings, such as a community health center in a Latino neighborhood. I believe each of us needs to find a place of comfort. There are many fascinating opportunities out there. Each student should cherish the reasons for becoming a doctor and not succumb to the pressure to specialize in fields where the hours are limited and the money is not. Great satisfaction can be found in caring for people who are vulnerable, appreciate what you’re doing, and invite you into their lives. Some people are drawn to international care or global health, while others have flourished in community health centers and homeless programs. I urge students to explore serving different populations and discover the places where their hearts and minds are at ease.

James O’Connell, MD, is president of Boston HealthCare for the Homeless, a physician in the Departments of Medicine at Massachusetts General Hospital and Boston Medical School, and a clinical instructor of medicine at Harvard Medical School.

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