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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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James Dunford, MD, is a professor of clinical medicine and surgery in the Department of Emergency Medicine at the University of California San Diego (UCSD) Medical Center and the medical director for the city of San Diego. He received his medical degree from Columbia University College of Physicians & Surgeons, is board certified in emergency medicine and internal medicine, served as the medical director of San Diego Life Flight, and founded the UCSD Emergency Medicine Residency Training Program. Dr. Dunford's interests include translating scientific advances in cardiovascular disease and trauma to the community. He received the Pursuit of Solutions Research Award from the U.S. Interagency Council on Homelessness in 2007.

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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David Buchanan, MD, MS, is an assistant professor of medicine at Northwestern University in Chicago, and the chief medical officer at the Erie Family Health Center.

Sharad Jain, MD, is an associate professor of clinical medicine at the University of California, San Francisco, and is director of the UCSF/SFGH Primary Care Medicine Residency Program.

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