

Health Care and Homelessness

November 2021, Volume 23, Number 11: E833-904

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AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E835-839

FROM THE EDITOR

Homelessness Is an Ethical Issue in America

G. Robert Watts, MPH, MS

Health Advocacy for People Experiencing Homelessness

The National Health Care for the Homeless Council's (NHCHC's) training, research, and advocacy support clinicians and the 1 million patients¹ served annually in 300 Health Care for the Homeless federally qualified health centers (FQHCs) and 100 medical respite programs. The NHCHC's work is fundamentally ethical in nature. The NHCHC community is galvanized to serve a population that is often shunned by society and large segments of the health care system: people experiencing homelessness. Its mission statement is expressed in moral terms: "Grounded in human rights and social justice, the National Health Care for the Homeless Council's mission is to build an equitable, high-quality health care system through training, research, and advocacy in the movement to end homelessness."² Rights, justice, and equity are fundamentally ethical concepts.

In the introduction to this theme issue, I offer 3 reasons why we, as members of society and clinicians, are ethically obligated to offer homeless health care in the United States and to work to end homelessness: (1) homelessness harms people's health and well-being; (2) homelessness harms the health system and health professionals; and, finally, (3) homelessness is a result of **inequitable policies**, practices, and choices our society has made.

Homelessness as a Health Hazard

The health effects of homelessness are grave, with higher incidence and severity of illness and injury among people experiencing homelessness.³ Chronic conditions, such as diabetes, hypertension, and heart attack are almost twice as prevalent among people experiencing homelessness than in the general population⁴; substance use disorders are 3 times as prevalent; and depression and hepatitis C are more than 6 times as prevalent.⁴ Homelessness also has serious developmental effects on children, and children experiencing homelessness have higher rates of mental distress, physical illness, and dental problems.⁵ Lacking stable housing makes treating every condition more difficult and **further damages health**. People who die on the streets on average live roughly 30 fewer years than the US life expectancy, and the age-adjusted death rate of the homeless population is at least twice that of the general population.^{6,7,8,9}

Homelessness Is Harmful to Our Health System and Health Professionals

People experiencing homelessness access primary care less frequently because they are often uninsured and have experienced marginalization and stigma by health care

organizations, resulting in their more frequent emergency department use and presentation with comorbid conditions that are more acute because they have been untreated.¹⁰ People experiencing homelessness are hospitalized at up to 4 times the rate of the general population and have longer inpatient hospital stays.^{10,11} Because these patients' conditions are exacerbated by lack of care and unstable housing, costly intensive care is devoted to addressing needs of persons with conditions that could have been—and should have been—treated earlier in primary care settings.

Moral injury and moral distress occur among health care professionals placed in situations in which they feel they cannot provide high-quality care and healing or in situations in which they feel constrained from doing what they believe to be right for a patient.¹² Moral injury and moral distress are the reality every day for many clinicians who are trying to treat people experiencing homelessness. Clinicians experience distress when treating persons whose conditions have their roots in nonmedical causes that are socially determined. Following protocols that do not promote patients' best interests or that result in patients' discharge to unsafe conditions can generate feelings of frustration, burnout, and moral injury among well-intentioned professionals.

Homelessness Is a Result of Society's Choices That Promote Inequity

Ethics involves evaluating choices in light of their effects or their alignment with principles, such as justice and fairness. I want to be clear: the scale of homelessness in the most powerful and wealthy country on earth demonstrates that mass homelessness is a social problem resulting from many choices society has made over time. The US Department of Housing and Urban Development estimates that well over 500 000 people experience homelessness on any given night in the United States.¹³ More than a third of these vulnerable human beings are “unsheltered,” exposed to the elements in parks, on subways, **on the streets**, and in the woods. In any given year, the US Department of Education states that approximately 1.5 million of our nation's children (eg, the population of the state of Maine¹⁴) experience homelessness.¹⁵

The high numbers of racial minorities experiencing homelessness are a direct result of inequitable federal laws, policies, practices, and broken treaties with Indigenous nations that resulted in transgenerational trauma, forced migration, segregation, and denial of educational and employment opportunities and basic human rights. African Americans represent 13% of the general population but constitute more than 40% of people experiencing homelessness¹⁶; Native Americans/Alaskan Natives make up 1.7% of the general population but constitute almost double their share of the homeless population.^{13,17} The largest cause of mass homelessness was a roughly 75% reduction between 1979 and 1982 in federal funding to make housing affordable for poor people,¹⁸ and this housing shortage extends to the present day. Funding has remained intractably low since 1982 and is only available to 1 of 4 households that qualify for federal rental assistance.¹⁹ Compare that to tax subsidies promoting home ownership—almost all of which go to wealthy Americans, are available to everyone who qualifies, and exceed \$200 billion per year²⁰—to see a clear example of inequitable policy and practice.

Beyond Compassion

Delivering high-quality health care to people experiencing homelessness while working to end homelessness puts moral motivation and good intentions into action. Given systemic causes of homelessness, which have excluded some groups from opportunities while unfairly conferring advantage to others, **homeless health care** is about more than

expressing compassion. As admirable and ethical as compassion is, responding robustly to remedy structural causes of homelessness is a matter of justice. We can largely end homelessness on a massive scale. To continue to choose not to do so is unjust and immoral.

This theme issue of the *AMA Journal of Ethics* addresses ethical implications of this struggle to deliver high-quality homeless health care while working to end homelessness and considers clinicians' and organizations' roles and obligations to deliver equitable care and promote justice.

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Citation

AMA J Ethics. 2021;23(11):E835-839.

DOI

10.1001/amajethics.2021.835.

Acknowledgements

I wish to thank the director of implementation research at the National Health Care for the Homeless Council, Dr Alaina P. Boyer, for serving as editor of this issue and her team, especially Brett Poe, for curating this theme issue's content.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

A microscopic image of plant tissue, likely a cross-section of a stem or leaf, showing various cell structures and vascular bundles. The image is in shades of blue and purple, with some cells appearing more densely packed than others.

AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E840-846

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Autonomy of Persons Experiencing Homelessness Be Balanced With Public Health During a Pandemic?

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Abstract

The COVID-19 pandemic underscores long-standing challenges to the health of persons experiencing homelessness. This case commentary considers primary care clinicians' response to a patient who declines COVID-19 testing and isolation. This article also considers other outbreaks in the United States in which the autonomy of persons with low income or persons of color was neglected and calls for community engagement, policies that center interests of marginalized groups, and economic relief, including supportive housing.

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Case

Ms L is a 48-year-old woman with currently uncontrolled type 2 diabetes mellitus and a history of anxiety and depression. In March 2020, she presents with a persistent cough, shortness of breath, fatigue, and myalgia to a Health Care for the Homeless Program site. She reveals during an initial screening that she's been self-medicating with acetaminophen and alcohol.

Ms L declines testing for COVID-19 and for hotel-based non-congregate (isolated) housing funded through a Federal Emergency Management Agency program. Clinic staff members express concern to Ms L about her health and about her capacity to infect others. Despite education by staff about the importance of isolation and testing, Ms L states that she will return to her usual dwellings—sometimes in public transportation stations or vehicles, sometimes in an encampment, or sometimes in a women's congregate shelter, which has units for individual sleeping quarters and includes kitchens and other shared spaces.

When Ms L leaves the clinic, concerned clinic staff members confer with a member of Health Care for the Homeless legal counsel to see whether there is something else they can or should do to protect Ms L and others in the community. The attorney warns that

they should not attempt to alert shelters, public transit authorities, or police and emphasizes that Ms L has a right to make personal decisions with which others might disagree, since Ms L has decision-making capacity. Members of the staff feel discouraged after hearing this advice and still feel that, as clinicians, they have a duty to try to help protect members of the public. They wonder what to do.

Commentary

As clinicians with the Health Care for the Homeless Program, we commit daily to the ethical principle attributed to the Hippocratic Oath, *primum non nocere* (“first, do no harm”). However, we frequently find that patient-centered health care for people who lack housing presents a series of imperfect, insufficient choices. The COVID-19 pandemic made these choices common and complex. In this commentary, we shed light on how this case can be approached by examining (1) the care model and ethical framework of the Health Care for the Homeless Program, (2) historical precedent of fear-driven responses to prior US outbreaks involving people experiencing homelessness, and (3) ethical frameworks that offer insights into how clinicians can approach similar circumstances.

Health Care for the Homeless

The Health Care for the Homeless Program is ethically grounded in person-centered care, respect for autonomy, and respect for resilience. Person-centered care, as defined by the Institute of Medicine, entails “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”¹ Respect for a person’s autonomy means ensuring that the person is free from controlling interference from others and free from limitations, such as lack of understanding, that might prevent their making an informed decision or meaningful choice.² And respect for resilience presumes the strength and capacity of persons with whom we work and requires a **trauma-informed understanding** of their behavior and events in their lives.³

We also strive to “meet people where they’re at.” Every day we see patients juggling impossible circumstances who manage to care for each other and their own health and well-being. They do all this while living without their fundamental right to housing being met. Developing trusting relationships with persons we serve can guide us in supporting them as they overcome extremely challenging situations. Connections among Health Care for the Homeless Program sites and county and national public health agencies enable us to mobilize resources and to respond with care to our patients’ needs.

The COVID-19 pandemic has prompted redesign of typical walk-in models of care, in which persons seeking care enter the lobbies of shelters and drop-in centers. We now screen patients (eg, for COVID-19) by phone and provide many social and behavioral health services by telephone or video. We also expanded our street outreach team, ensure rapid access to COVID-19 test results, and have isolation and quarantine teams to provide comprehensive health care to people experiencing homelessness who have been exposed to or tested positive for COVID-19.

Yet, despite our training, experience, and resources, we still struggle to navigate how best to express respect for patients’ autonomy while minimizing harm to public health.² We’ve had little guidance from local or national leaders on managing this tension. In fact, we’ve seen extreme **politicization** of recommended safety measures, which has resulted in a dearth of guidelines we can use to respond to patients like Ms L.

Fear-Driven Public Health Responses

Evidence suggests that measures to protect the public from COVID-19 discriminate on the basis of socioeconomic status, race and ethnicity, and language.⁴ Protective behaviors, such as social distancing and working from home, are privileges less available to workers with low-income.^{5,6} Congregate settings for the poor, such as homeless shelters, have led to rampant spread of the virus.⁷ And contact tracing across the United States is complicated by lower access to COVID testing in many low-income neighborhoods, especially among those that have faced long histories of inaccessible health care.⁸ As a result, COVID-19 infections and related deaths have disproportionately affected Black and Indigenous people and other people of color with low income in the United States. In July 2020, risk of death from COVID-19 was 9 times higher for people living in poorer “substantially non-White” counties than in poorer “substantially White” counties.⁹ Disproportionately higher COVID-19 mortality rates among racial and ethnic minorities become even more striking when age-standardized for premature mortality. Non-Hispanic Black and Hispanic people lost nearly 7 times as many years of life—and American Indian/Alaska Natives nearly 9 times as many years of life—before age 65 as non-Hispanic White people between February 1, 2020 and July 22, 2020.¹⁰ Furthermore, the economic impacts of COVID-19 threaten to worsen centuries-long **patterns of structural racism** in the US housing market, with people of color disproportionately at risk for displacement from rental units.¹¹

Historically, public health responses to disease outbreaks in the United States have discriminated against the “other” based on xenophobia and classism.⁴ From smallpox to tuberculosis to HIV, disease containment policies have often focused on the poor and historically marginalized groups, worsening inequities in the name of the public good.¹² Tuberculosis provides the most relevant recent example of a disease that specifically affected the homeless community. In the 1990s, New York City mandated directly observed medication therapy, physical examinations, and detention of people to prevent disease spread or to enforce treatment.¹³ While such coercive measures were used on less than 4% of the more than 8000 patients with tuberculosis at that time, the regulations affected 17% of patients experiencing homelessness, 10% to 29% of patients using various types of drugs or alcohol, and 38% of patients with a history of incarceration.¹³ Similar orders in California in the 1990s used civil detention and arrest to treat tuberculosis in 1.3% of presenting cases and had a similarly disproportionate impact on marginalized populations.¹⁴ Furthermore, even with such draconian efforts, only 84% of detained persons completed treatment, and only 41% completed treatment within 12 months.¹⁴ Oscherwitz et al suggested that greater availability of housing and psychosocial services would result in less need for dependence on punitive approaches.¹⁴ Unfortunately, such suggestions led to little change.

Similar to other public health crises in our country’s history, the COVID-19 pandemic has focused attention on and pouring money into projects other than those that strengthen our society and address long-standing inequity. All the while, people living in poverty, who include disproportionate numbers of Black, Indigenous, and other people of color, continue dying at staggeringly disproportionate rates, leaving behind families who lack the support for housing, food, and basic income they need to survive.

Bioethical Frameworks

Bioethical principles and international law could offer clinicians guidance on how to navigate this complex confluence of challenging circumstances. Such guidance could detail how to balance the rights of individuals against those of the public and how to

support public good. The Siracusa Principles, developed by the International Covenant on Civil and Political Rights in 1985, contain explicit criteria concerning when and how to override rights of individuals for the health of the public. Such guidance emphasizes that limitation of rights cannot “involve discrimination solely on the ground of race, colour, sex, language, religion or social origin.”¹⁵ Given the social origin of homelessness, this guidance suggests that it would be inappropriate to impose any limitations on the rights of Ms L solely due to the circumstance of her being homeless. Yet broad interpretation of these principles leaves little latitude for protection of the health of the public.

Bioethics scholars Matose and Lanphier suggest that the “harm principle” be the basis of limitations of rights during the COVID-19 pandemic. They propose a “stringent requirement to prioritize the prevention of harm to others”¹⁶ with regard to both disease transmission (eg, social distancing and masking) and unintended harms of social restrictions (eg, lost employment, food insecurity, and violence for those sheltering in abusive homes). Preventing harm from disease transmission might suggest that Ms L be required to use available hotel relocation options. However, this requirement would infringe on Ms L’s autonomy and eliminate her agency in the decision about how to keep herself safe. Prevention of harm could also support provision of supportive housing (rather than compelled housing) as a fundamental human right required for Ms L’s overall health and well-being related to both COVID-19 and her other medical and behavioral health conditions.

Given the current vacuum of US leadership, with public health officials increasingly quitting their jobs due to threats of harm from their fellow community members,¹⁷ health care clinicians and local public health officials are left to navigate these challenges on their own. So, those of us who work for the Health Care for the Homeless Program will do as we’ve been trained to do: we’ll maintain our ethical framework of *primum non nocere* and person-centered care, respect for autonomy, and respect for resilience and build relationships with those we serve. Such relationship building—rooted in establishing trust, harm reduction, and trauma-informed care—aligns with expert opinion about dealing with difficult cases of COVID-19 among people experiencing homelessness.¹⁸ We also know it’s currently our only hope. By respecting Ms L’s autonomy, maybe over time she’ll trust us enough to partner with us to look after her own health and decrease the risks she poses to herself and to her broader community.

Conclusion

Because clinical care alone is insufficient during these difficult times, we call for leadership to develop policies that “center at the margins”—that is, policies that are designed with authentic input from people experiencing homelessness and other forms of oppression and marginalization.¹⁹ We believe such approaches could result in community-driven solutions that promote equity and overcome historic discrimination. They would focus on acceptable housing solutions, such as long-term permanent supportive housing. Such long-term solutions offer options that promise to overcome some of the tension inherent in this case between Ms L’s autonomy and her best interests and avoid the need to compel at-risk people to shelter in hotels and other temporary settings during a pandemic. Forward-thinking, long-term solutions like permanent supportive housing might allow us to emerge from this time of crisis stronger and with more humane policies.

Until that leadership arrives and policies are made to control this pandemic and others that may come after it, we will remain at work on the margins. We will work to build trust

and rapport with people like Ms L who most often have very important and relevant reasons not to trust clinicians and whose autonomy is often deeply tied to their strength and resilience. We know such approaches offer us the best hope of avoiding harm to patients or to the public while also respecting patient autonomy until society finds the will to ensure that all people have access to affordable, supportive housing.

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Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2021;23(11):E840-846.

DOI

10.1001/amajethics.2021.840.

Acknowledgements

Dr Vickery's work is supported by National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health award K23DK118117 (Hennepin Healthcare Research Institute).

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. This article is the sole responsibility of the author(s) and does not necessarily represent the views of the National Institutes of Health or the US government. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E847-851

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Help Homeless Trauma Survivors Make Irreversible Surgical Care Decisions?

Eva V. Regel, MS, MSW, LICSW, MBE

Abstract

Important but frequently overlooked childhood trauma outcomes can manifest later in patients' lives and include neurophysiological influences on language perception and expression, memory, attention, abstract reasoning, emotional regulation, and executive functioning. Therefore, when interacting with patients experiencing homelessness, mental illnesses, and substance use disorders, clinicians should adopt a trauma-informed approach to generating deeper understandings of patients' neurobiological makeup and psychosocial histories, especially when discussing interventions and during informed consent.

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Case

M is a 32-year-old transgender woman who is unsheltered. She has an extensive history of physical, emotional, and sexual abuse, which began when she was 5 years old. M has had many encounters with the health care system and, when admitted as an inpatient, frequently left against medical advice. During her last hospital admission, a surgical team recommended that M undergo an amputation. M left against medical advice but was readmitted 4 days later with tachycardia, hypertension, and a fever. A surgical team again emphasized that amputation was very likely needed to save M's life. Despite many conversations, M remained frightened and refused surgery, but the surgical team had no good reason to doubt her capacity to make health decisions.

When M spoke with the team's social worker, SW, she explained that she felt rushed to consent to amputation and that she neither trusted her physicians' desire to help her nor understood why she needed an amputation to live. She expressed frustration with clinicians "who use big words to make me feel stupid and force me to do what they want." M continued, "They have no idea what my life on the streets is going to be like when I don't have this limb anymore." M also shared with SW that she often does not understand what she is told, is scared, and needs more time to think and ask questions.

Based on these conversations with M, SW suggests to her fellow team members that slower speech, short sentences, writing down key points, and making more time for questions could help clinicians feel less frustrated about M refusing indicated and much-needed surgery. It would also help M consider what such surgery would mean for her now and when she leaves the hospital.

Commentary

The US Department of Housing and Urban Development estimated that 18 of every 10 000 people in the United States were experiencing homelessness on a single night in January 2020.¹ Research on causes of homelessness indicates that child abuse is a leading cause of [homelessness among adolescents](#) and adults, especially women.^{2,3,4} Patients experiencing homelessness are also psychosocially complex, have numerous comorbidities, and have had many encounters with health care professionals and organizations.⁵ This article examines how psychosocial trauma can affect decision-making capacity and argues that clinicians interacting with patients experiencing homelessness, mental illnesses, and substance use disorders should adopt a trauma-informed approach to deepen their understanding of patients' neurobiological makeup and psychosocial histories, especially when discussing interventions and during informed consent.

This Decision in Patient Context

Patients experiencing homelessness experience tremendous adversity and instability in their everyday lives, so, as any of us might, they tend to strive for [control and autonomy](#), especially in acute care settings, which can be triggering for some patients. Making a high-stakes decision about an irreversible intervention is enmeshed in unfamiliar, sometimes intimidating power dynamics. Lack of careful attention to patients' responses and nonverbal cues can compound patients' grief and sense of feeling overwhelmed. Under pressures of managed health care, clinicians tend to spend less time with patients, which can compromise the quality of consent processes and undermine patient-clinician trust. Behavioral and cognitive consequences of extensive, prolonged childhood trauma experiences negatively affect memory system development (including the hippocampus, amygdala, and frontal cortex) as well as the development of brain structures involved in executive functioning (including the orbitofrontal cortex, cingulate, and dorsolateral prefrontal cortex).^{6,7} These developmental compromises result in slowed processing of language and information and the need for more time for decision making and problem solving.^{6,8,9} Posttraumatic stress disorder (PTSD) can also prompt childhood trauma survivors' heightened perception of threat in ambiguous situations and negative interpretative bias.¹⁰ Add some clinicians' limited understanding of patients' neurocognitive trauma histories, and you have a perfect storm of factors bound to make patients who are already navigating myriad uncertainties of life on the streets refuse interventions they might need.

Importantly, altered cognition does not necessarily imply that trauma survivors have compromised decision-making capacity.¹¹ Capacity can vary over time for many of us. In M's case, the stress of making an important decision, lack of privacy, power inequity in patient-clinician communication, distrust, and feeling that she lacks agency are key contextual features of the decision she faces. Acting beneficently and without doing harm also requires clinicians' sensitivity to neurobiological effects of trauma when assessing M's capacity. Facilitating M's self-determination responsibly means assessing her capacity under the most favorable conditions,¹² perhaps with cognitive enhancements (eg, visual education, repeated conversations, corrective feedback, and

plain language use), which could improve her understanding and her capacity to **give informed consent** or informed refusal. The delivery of prospective risks and benefits of an intervention to patients like M should create and nourish conditions that minimize triggers, avoid retraumatization, promote emotional well-being, and express respect for autonomy. A careful and sensitive informed consent process based on enhanced communication, trust, and respect facilitates patients' sense of control in their care and their lives.^{13,14}

Communicating for Self-ownership

Self-ownership is a concept critical to health care workers' interactions with childhood trauma survivors. These patients' experiences of self-ownership situate their capacity and agency in processes of informed consent or refusal. In my experience, patients like M tend to be acutely aware of possible threats to their integrity and dignity, so helping them motivate their self-determination and strivings for autonomy are essential in patient-clinician relationships and communication. Common conditions in acute care settings (eg, lack of privacy, limited control) can trigger patients with PTSD to respond with "flight-fight-freeze," which we can easily observe in M's behavior. *Flight* is expressed in her history of leaving against medical advice; *fight* could be understood in her resistance to consenting to indicated care recommendations; and *freeze* could be understood in her befuddlement about this decision and attempts to make sense of unfamiliar environs, behaviors, and words. Clinicians have ethical obligations to consider how patients with trauma histories can be disadvantaged by those histories (eg, by not being able to process information quickly or efficiently) but not necessarily disabled by them when making decisions about their health and lives (eg, they can weigh prospective risks and benefits and evaluate consequences).¹⁵

Clinicians caring for patients with psychosocial trauma who also experience homelessness should have a solid working understanding of how to avoid retraumatizing patients like M. A 2020 report by the Substance Abuse and Mental Health Services Administration on the specific role of the COVID-19 pandemic in our social interactions is applicable more generally to trauma-informed communication and to our thinking about M's case:

COVID-19 has caused major economic devastation, disconnected many from community resources and support systems, and created widespread uncertainty and panic. Such conditions may stimulate violence in families where it didn't exist before and worsen situations in homes where mistreatment and violence has been a problem.¹⁶

Trauma-informed communication means incorporating understanding of how psychological and neurophysiological effects of a patient's trauma history can affect how that patient responds to the delivery of complex clinical information. A careful, sensitively stewarded informed consent process will support and foster patients' right to give informed consent or refusal and nourish their sense of self-ownership and agency. **Trauma-informed communication** also means that time must be allowed; as considered earlier, a rushed conversation before a procedure can be a trigger for patients with minimal capacity to cope with unfamiliar information and decision pressure. Clinicians are ethically obligated to help all patients make decisions about their care in the context of their values, goals, and personal histories. To do so requires establishing trust, a strong therapeutic relationship, and, for patients like M, an understanding of how they are situated by their backgrounds to make decisions.

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Citation

AMA J Ethics. 2021;23(11):E847-851.

DOI

10.1001/amajethics.2021.847.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E852-857

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Training Clinicians to Care for Patients Where They Are

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Abstract

Homelessness remains a pervasive, long-standing problem in the United States and is poised to increase as a result of the COVID-19 pandemic. Individuals experiencing homelessness bear a higher burden of complex medical and mental health illnesses and often struggle to obtain quality and timely health care. The United States desperately needs to train a workforce to confront this large and growing crisis, but few health professional schools currently devote curricula to the clinical needs of people experiencing homelessness. This article discusses educational and curricular strategies for health professional students. Understanding the health needs of—and the social influences on the lives of—people experiencing homelessness is crucial for addressing this health equity challenge.

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Preparing for the Health Impacts of Poverty

On any single night in January 2020, 580 466 people in the United States were estimated to be experiencing homelessness, up 2.2% from 2019.¹ In 2017, it was estimated that more than 1.4 million people experiencing homelessness used an emergency or transitional housing program.² The COVID-19 pandemic, together with economic recession and high unemployment, has exacerbated this crisis. People experiencing homelessness rarely have single risk factors or conditions; they tend to bear an inequitable burden of trimorbidity (eg, co-occurring medical, psychiatric, and substance use disorders), which increases premature death risk.^{3,4,5} Health, racial, and economic inequity narrow their chances for better living conditions, and many health professionals are ill equipped to respond to these patients' needs. Cultivating a capable workforce is key to motivating better service delivery to members of this vulnerable population.

Interprofessional Learning

A small number of health professional schools do devote curricular time to the clinical needs of people experiencing homelessness. Evaluation of limited medical and nursing

education efforts published to date have shown progress.⁶ In the early 2000s, second- and third-year primary care internal medicine residents at an urban public hospital training program completed a clinical elective in settings where health care is offered to people experiencing homelessness.⁷ One program required primary care interns to offer clinic-based care to patients experiencing homelessness,⁸ and one physician assistant program integrated street medicine, which required students and preceptors to care for people living outside. The Doctors Without Walls-Santa Barbara Street Medicine program at the University of California, Santa Barbara, offers a seminar each winter, and the University of California, San Francisco (UCSF), is developing street medicine didactics and clinicals open to nursing and medical students.

Nurses have long cared for people experiencing homelessness, and public health nursing embodies an ideal of social justice by offering essential services to vulnerable persons. In tenements and settlement houses of the late 1800s, as well as in modern-day shelters and other sites, nurses have been caring for impoverished patients, embracing service-learning and research opportunities, striving to mitigate bias and stigma, and improving access to care.^{9,10,11} In 2019, UCSF launched the Benioff Homelessness and Housing Initiative, with a focus on homelessness research, policy, and interprofessional education.⁹ That same year, Harvard University launched the Initiative on Health and Homelessness at the Harvard T.H. Chan School of Public Health dedicated to education, service learning, and research¹² and, in 2020, piloted a 6-hour “nanocourse” on homelessness for medical and public health students. In 2021, this mini-course grew to become a full course, including a case study on [Boston Health Care for the Homeless Program’s](#) response to COVID-19, exploration of the relationships between structural racism and homelessness, speakers with diverse backgrounds, and experiences in active learning settings.

Selecting what content to include in health professions curricula is as important as considering how to, and who should, teach it. Ideally, health professions students should learn about homelessness’ influences on health from community experts and from persons with lived experience. Consumer advisory board members and advocates for people experiencing homelessness are well situated to describe clinical and ethical complexities of health care for this population and to advise about best practices in disease prevention and service delivery. Explorations of clinician biases, who clinicians think “the deserving poor” are and why, and how to distribute resources are key ethical and resilience-building questions that should be included in curricula. Complex confluences of poverty, structural racism, siloed care, and homelessness necessitate mastering “complicated medicine”¹³ and interprofessional collaboration (eg, among physician assistants, nurse practitioners, psychologists, psychiatrists, dentists, social workers, case managers). Interdisciplinary learning allows students to collectively examine their own and others’ attitudes toward people experiencing homelessness, recognize and value colleagues’ and community members’ expertise, learn from local organizational leaders, and test career choices.^{14,15,16} Improving care coordination, clinical management, and disease and injury prevention among people experiencing homelessness requires health professional schools to make a commitment to serving the most vulnerable, a defining feature of health professionalism.

Broad Applicability

Instruction must include cross-disciplinary care management of multiple clinical conditions and facilitate students’ and trainees’ recognition of how social determinants (eg, poverty, racism, food and housing insecurity, trauma history, immigration status,

limited opportunities to practice hygiene, violence, limited transportation access) influence the health of individual patients and entire communities. These skills are not singularly relevant to people experiencing homelessness but are applicable across populations that are impoverished. The National Health Care for the Homeless Council is a key resource for training and advocacy and facilitates health professional programs' partnerships with community health organizations to teach skills practiced daily in 300 Healthcare for the Homeless programs across the United States.¹⁷

Collaboration is critical. Clinicians' capacity to deftly collaborate in order to integrate medical, dental, psychosocial, and substance use strategies at a single point of care for a single patient relies upon how well they are trained to diagnosis and treat during encounters or at sites (eg, the streets, shelter-based clinics, rehabilitation programs) that are atypical in health care. Clinicians' capacity to skillfully collaborate is also key to helping patients—during single or multiple encounters—manage acute and chronic disease, injury, or recovery with short- and long-term plans that persons experiencing homelessness can navigate, despite the persistent conditions of deprivation, neglect, and instability they face daily. Supporting students and trainees also means **preparing them emotionally** for their exposures to conditions of homeless life, which will be unfamiliar to many, if not most, health professionals in training. Such support can be enhanced by further collaboration and collective engagement in processing what trainees witness and how they respond.

Conditions of poverty and diverse presentations. Health education for populations experiencing homelessness means unlearning that conditions generally regarded as rare (eg, scurvy,¹⁸ pellagra,¹⁹ frostbite,²⁰ hypothermia,²⁰ *Bartonella quintana*²¹ from lice infestation) in resource-rich parts of the world are common among people in the United States who experience homelessness. People experiencing homelessness also suffer excess burdens of cancer,²² mental illness,²³ and substance use disorders²³ that have often gone untreated for longer than many health professions students or trainees are used to seeing, so rigorous health curricula to address the needs of people experiencing homelessness must incorporate acute and chronic noncancer pain management while also exposing students and trainees to detoxification protocols for managing substance (eg, alcohol, opioid) withdrawal symptoms.

Widespread trauma. Compared to women in the general population, women experiencing homelessness have higher rates of childhood physical abuse (67% v 20%) and sexual abuse (55% v 32%), respectively.²⁴ For many who lack control over their environment and experience their life and health choices as limited by social determinants, healing from trauma tends to be inequitably compromised, if not impossible. Importantly, racial trauma and the impacts of structural racism on homelessness should be integrated throughout clinical training. These improvements will better prepare health professions students to improve not only health care delivery and outcomes but also social and structural determinants that perpetuate homelessness.

Beyond the Pandemic

Despite tragic losses, the **COVID-19 pandemic** offered unique opportunities for clinicians to care for people experiencing homelessness. Efforts to test, social distance, quarantine and to provide safe shelter, food, clothes, other needed services, along with increases in locations and numbers of care sites,²⁵ demonstrate key successes. US public health capacity was shown to be inadequate overall, underscoring the need to

capitalize on these successes through academic health programs' building a capable health care workforce that motivates improved—and equitable—health outcomes in hospitals, clinics, shelters, and everywhere we live.

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Citation

AMA J Ethics. 2021;23(11):E852-857.

DOI

10.1001/amajethics.2021.852.

Acknowledgements

Dr Koh's work is supported by grants from the Robert Wood Johnson Foundation.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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ISSN 2376-6980



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E858-863

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Bringing Health Professions Education to Patients on the Streets

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Abstract

This article considers strategies for illuminating health systems' structural violence toward people experiencing homelessness and for resisting incursion of moral injury to health professional learners. This article also canvasses the nature and scope of educators' obligations to teach in patient-focused ways that motivate equity and students' capacity to serve some of the country's most vulnerable residents in clinical settings or on the streets.

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Resisting Education Embedded in Violence

Medical education is at a threshold for much-needed change. Although academic health learning models in the United States have standardized and improved health professional training, the patients served (particularly excluded populations) often just don't get their health needs met by clinicians and organizations.^{1,2,3,4,5,6} Medical education is embedded in structurally violent systems in which the well-being of many patients (eg, those suffering domestic violence, addiction, or homelessness) is largely ignored. Patients experience dehumanization and students may too easily become co-conspirators.^{2,3,6,7}

The process through which **students are desensitized** has been referred to as the *hidden curriculum* and is a form of moral injury.⁸ Medical educators have made efforts to bridge the reality gap between traditional health systems and the real lives of patients through an emphasis on patient-centered care, the social determinants of health, health disparities and equity, narrative medicine, and other frameworks that shift the focus from the health system to those it should serve.^{1,3,7,8,9} However, these efforts still fail to provide the transformative experience that a truly immersive setting might provide. In this article, we will discuss how street medicine can serve that role in medical education.

A Classroom of the Streets

Street medicine is an emerging field of practice throughout the world. It is defined as the direct provision of health care to those experiencing unsheltered homelessness.⁴ Teams of health and social service experts regularly visit rough sleepers where they live in

campsites, in alleys, along riverbanks, and under bridges. Although a few pioneering programs in Calcutta,¹⁰ Boston,¹¹ Chile,¹² and Pittsburgh¹³ had emerged by the 1980s and 1990s, the grassroots street medicine movement gained momentum only after the turn of the millennium. This movement was catalyzed by the first annual International Street Medicine Symposium in Pittsburgh, Pennsylvania, in 2005.¹⁴ At that time, the term *street medicine* was coined to describe this new field of medicine. Participants at this first meeting strongly agreed on 2 specific points. They wanted to continue annual meetings to build the movement, and they wanted to involve and foster their students. The conviction of these leaders was that including students in the care of rough sleeping patients was potentially of benefit to the medical education system. The annual symposium (now hosted by the Street Medicine Institute) has expanded, but the emphasis on medical education has remained strong. Every year students contribute posters, presentations, and workshops. Throughout the United States, academic leaders have incorporated medical education into local street medicine programs.¹⁵ It was usually necessary for them to create the street medicine programs first in order to incorporate medical education secondarily. Wherever medical education is provided in the context of street medicine, it has become affectionately known as “the classroom of the streets.” Let us explore some of the advantages that this unique classroom offers.

Lessons From the Classroom of the Streets

Rehumanization. Students engaged in street medicine are offered a rare opportunity to become deeply immersed in a cultural context that would be otherwise inaccessible. Typically, students encounter rough sleepers in tense—sometimes hostile—settings, such as emergency departments and inpatient hospitalizations.^{3,4,16,17} While on street rounds, students are physically able to go to the places where this population lives and experience the “view from the streets.” Street rounds allow students a far more organic, relaxed setting for interactions.¹⁸ Learners see, hear, and even smell the conditions in which rough sleepers struggle to exist. This experience enables students to respond not just as a detached clinician, but as a human being.¹⁵

The change of perspective has deep existential significance for students, as it places them within the reality of the excluded person’s life instead of the converse.^{2,5,15,16} The student learns that any healing process must be derived from the phenomenological perspective of the other. The rough sleeper becomes the teacher with whom the student must gain trust to be effective. Coupled with appropriate reflective discourse, students are able to shift their model of the patient-physician relationship from paternalism to solidarity, aligned with the principles of Paulo Freire as described in his seminal work, *Pedagogy of the Oppressed*.¹⁹ Although this transformation of perspective may be achieved in standard clinical settings, it is greatly enhanced on the streets where paternalism can be challenged. Even after a 1-month street medicine elective, students have later expressed to me that the experience changed forever how they viewed all patients.

Social justice. The learning environment of a typical street medicine program offers other advantages. While global education is well recognized as providing cultural awareness and the opportunity to compare the American health system with other health systems, street medicine constitutes a significant cultural plunge and a chance to see the shortcomings of the American health system from the margins. It also can be practiced in convenient locations. Street medicine naturally incorporates an analysis of inequity in social determinants of health, such as poverty, addiction, mental illness, racial and gender injustice, housing, and the effects of the criminal justice system. In the

street medicine context, these are not just abstract topics but immediate challenges that can be addressed through the principles of street medicine practice, including harm reduction, advocacy, health systems coordination, and continuity of care across a range of settings (streets, department accompaniment, inpatient street medicine consultations, respite care, and aftercare when housing is achieved). Unlike in the clinic-based practice environment, the social determinants of health are apparent, and usually the persons served are open to honest discussions about them. Street teams intimately experience the barriers to care, and students witness how to seek out and creatively engage with partners in the community. Academic street medicine programs often incorporate a rich mix of professionals, such as nurses, social workers, experts who formerly experienced homelessness, and others, all working together on the streets. These transdisciplinary teams naturally integrate to transcend their traditional professional boundaries.

Street Medicine Education

Traditional academic medicine has only recently embraced street medicine in its formal curricula. This is likely due to the nascence and novelty of the street medicine educational movement. Nonetheless, academic leaders and medical student groups have been quietly developing programs for the past 20 years. These range from highly developed programs like the [Boston Health Care for the Homeless Program](#)¹¹ to small student-initiated programs like Street Medicine Detroit.²⁰ Most academic street medicine programs have physician champions who work with the students on the streets and represent them at the faculty level within the institution. Generally, there is a community nonprofit partner that provides the street guides and social services, such as housing and addiction and mental health services.

Regarding safety, the Street Medicine Institute leadership is not aware of any instances of physical harm experienced by membership organizations' volunteers. In addition, a recent extensive review of the legal literature revealed no malpractice suits associated with the practice of street medicine (T. B. Hershey, P. Govil, unpublished data, 2019). Admittedly, it would be difficult for those experiencing homelessness to bring a malpractice suit in the context of street homelessness.

It is notable that students have often been the initiators of well-established programs. For example, the University of Rochester's Street Outreach Program²¹ was created by Emma Lo when she was a medical student, (She is now an assistant professor of psychiatry practicing street psychiatry at Yale University.) The Street Medicine Institute Student Coalition boasts 535 student members, 37 established US programs, 11 developing US programs, and 9 international programs at the time of this writing.²² Residencies are integrating street medicine as a longitudinal component of their training. Most recently, UPMC Mercy Hospital, in collaboration with Pittsburgh Mercy, established the world's first (nonaccredited) street medicine fellowship in 2019,²³ with another postgraduate street medicine fellowship being initiated at Integrative Emergency Services/JPS Health Network in July 2021.²⁴ To guide these diverse educational efforts, the Street Medicine Institute has formed the Street Medicine Educational Consortium.

Ethical Implications for Medical Education

Street medicine is a powerful and much-sought learning environment for health care students. My students in Pittsburgh often remark that street interactions are so "real." After a 1-month elective, one student described her experience by saying, "I got my

common sense back this month!” The divorce of clinical practice from patient reality is no longer acceptable to many of our best students. For them, it is painful and demotivating to witness the traumatic effects of a health system that largely serves itself and transfers blame for poor health to those who are excluded.¹⁵ As awareness of health **disparities related to race**, community trauma, poverty, gender, and other factors grows, the hypocrisy of looking away becomes intolerable and incompatible with the ethical foundations of our profession. The best students hunger not just for technical skills, but for meaningful engagement with the deeper forces that create the suffering that they witness. Such students understand that if health care is to be extended to those who have been excluded, we need to meet them in their own reality.²⁵ Street medicine students are energized and often become leaders in health care advocacy. For them, the marriage of social justice with medical education is long overdue. Academic medicine must not ignore the passion of such students. They will shape the future of our profession, but they need settings in which they can help reinvent health care to truly serve our communities. Street medicine can be a template for the meaningful, reality-based, and transformative kind of classroom needed to make the changes we need to make.

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Citation

AMA J Ethics. 2021;23(11):E858-863.

DOI

10.1001/amajethics.2021.858.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980

HEALTH LAW: PEER-REVIEWED ARTICLE

Should *Employment Division v Smith* Be Overturned?

Jake Greenblum, PhD and Ryan Hubbard, PhD

Abstract

Health professionals seeking religious exemption from caring for some patients or providing some interventions receive robust legal protection. Similarly, religiously affiliated organizations have great latitude in deciding which services to offer. These protections could soon become stronger, as the US Supreme Court considers 2 cases that revisit constraints on exemption claims established in *Employment Division, Department of Human Resources of Oregon v Smith* (1990). This article contends that overturning this case's precedent might result in clinicians claiming more religious exemptions, which, barring acts of US Congress, would erode the rule of law and increase risk of harm to patients.

***Smith* as Precedent**

In 1990, the US Supreme Court held in *Employment Division, Department of Human Resources of Oregon v Smith* that states can legally deny unemployment benefits to personnel terminated for using illicit drugs during religious ceremonies.¹ Justice Antonin Scalia's majority opinion states that persons should not be exempt from neutral laws of general applicability that conflict with their religious beliefs; exempting such persons "would open the prospect of constitutionally required religious exemptions from civic obligations of almost every conceivable kind."¹ The majority opinion employs the *valid secular policy test*, which requires laws' neutrality and general applicability, and which was first articulated in *Reynolds v United States* (1879).² According to this test, the government need only show that its actions serve a legitimate state interest and do not target particular religious groups when its actions burden those groups.

Smith was controversial among religious conservatives, although many liberals also opposed the ruling. Prior to *Smith*, the federal government used a *strict scrutiny test* to evaluate religious exemption claims. This test prohibits the government from substantially burdening a person's free exercise of religion, unless doing so is the least restrictive means by which government can pursue its compelling state interest. *Smith* was important because it signaled a change in law governing free exercise of religion by using the secular policy test instead of the strict scrutiny test. This article contends that overturning this case's precedent might result in clinicians claiming more religious exemptions, which, barring acts of US Congress, would erode the rule of law and increase risk of harm to patients.

Challenges to *Smith*

The outcry in response to *Smith* led Congress in 1993 to pass the Religious Freedom Restoration Act (RFRA),³ which restored the strict scrutiny test as a statutory standard for government actions that burden a person's **free exercise of religion**. Since 1997, however, the RFRA has only applied to federal law.⁴ But this restriction has not stopped 21 states from using the RFRA as a model for state laws based on the strict scrutiny test.⁵ In states without their own laws, *Smith*, with its valid secular policy test, remains the relevant legal standard by which exemption claims are reviewed. Despite the presence of the RFRA and state laws modeled on it, *Smith* still serves as a powerful constraint on religious exemption claim proliferation. Notably, in some cases, courts appeal to *Smith* even in states with laws based on the strict scrutiny test.

Appellate courts have cited *Smith* to justify rejecting religious exemptions in *Fulton v City of Philadelphia*⁶ and *Ricks v Idaho Contracting Board*.⁷ Plaintiffs in both cases requested that the Court revisit *Smith*. In *Fulton*, Catholic Social Services (CSS), a foster care contracting agency, sought exemption from the city's requirement to place children with all qualified families (eg, including lesbian, gay, bisexual, transgender, or queer families), which it stated would violate its religious beliefs. In June 2021, the Supreme Court held that Philadelphia violated CSS' exercise of its First Amendment right by excluding CSS from the foster care program due to its refusal to place children with same-sex couples.⁶ In *Ricks*, Mr Ricks sought exemption from a law requiring contractors to register their social security numbers with the state; he believes social security numbers are "a form of the mark,"⁷ which violate his religious beliefs. The Supreme Court declined to review the case in June 2021.⁸

Overturning *Smith*

With a conservative majority's record of expansive religious views,^{9,10,11,12} *Smith* could likely be overturned by the Court, with numerous consequences in the health legal landscape.

Undermining the rule of law. The rule of law expresses general agreement among persons subject to law to behave according to public norms.¹³ Persons in positions of authority and power (eg, judges, school administrators, or clinicians) are subject to law, like all of us, and, also like all of us, can seek exemption from laws perceived as violating their personal preferences or ideologies. When we contemplate exempting persons with authority and power from a law's applicability, it is nevertheless also necessary to consider such persons' **professional obligations**. Health professionals specifically owe duties of care to patients and members of the public, many of whom are ill, injured, or otherwise reliant on those professionals' responsiveness to their vulnerabilities. When health professionals **seek exemptions**, those whom they serve can be denied services or otherwise affected. Since overturning *Smith* would likely generate more religious exemptions, we argue that this consequence deserves ethical and legal consideration in terms of whether, when, and to what extent exemptions would violate the rule of law, exacerbate health inequity, or otherwise undermine the carriage of justice. Note that violating the rule of law might be legal (eg, a law that mandates presidential immunity from criminal investigation). Such a law would nevertheless be a violation of the rule of law.

There are legal means to mitigate some of these negative consequences. The Do No Harm Act, for example, would amend the RFRA to prohibit uses that harm third parties.¹⁴ The US Congress could also pass the Equality Act, which would broaden Title VII's

definition of public spaces to include “a good, service or program.”¹⁵ But even if Congress were to pass bills like these into law, the Court’s current makeup casts doubt on their long-term survival.

Risk of harm to patients, including discrimination. Incursion of harm violates the principle of nonmaleficence, of key importance to health professionalism.¹⁶ We argue that the plaintiffs in *Fulton* harmed children (by adoption delays) and prospective parents with the suit’s implicit messaging that sexuality or gender identity confers parental fitness. Although the Supreme Court declined to overturn *Smith* in *Fulton* because the city’s law was outside the scope of *Smith*,¹⁷ there are petitions currently pending before the Supreme Court requesting that it overturn *Smith*,¹⁷ which, if successful, could alter the health legal landscape for the worse through harms of service denial, inferiority messaging,¹⁸ and discrimination.

Professional complicity as a source of harm. Depending on one’s point of view, overturning *Smith* could be positive. Nonmaleficence, after all, cuts both ways: if persons with authority and power are harmed by a legal requirement to act in a way they deem immoral, how should this be considered? We respond again with a focus on clinicians’ professional obligations. Credentialed and licensed by states to offer legal, clinically indicated, and publicly regulated health services to persons in need, clinicians are obliged to prioritize the interests of people they serve.¹⁹ We suggest that even when carrying out one’s professional duties poses a risk of harm, ethically and legally, the interests of the most vulnerable patients should be prioritized.²⁰

Securing access to care. Individuals’ experiences of complicity matter and should have ethical and legal heft but not at the expense of patients’ access to legal, clinically indicated, and publicly regulated health services, which the federal government has a strong state interest in securing and protecting. Because we can plausibly expect that a post-*Smith* world would significantly reduce many patients’ access to care, state interest in securing patients’ access to care should become stronger “as the size and the number of businesses seeking exemption expands.”²¹

Liberty, autonomy, and respect. *Smith* is seen by some as disrespectful of persons with religious views that should be regarded as freely expressible in liberal pluralistic societies. But requiring health professionals to act against deeply held beliefs (eg, religious beliefs) does not necessarily violate their personal or professional autonomy.²² Expressing respect for fellow citizens’ views that differ from one’s own requires tolerance for those views and civility toward persons who hold those views. We suggest that it is neither intolerant nor uncivil to require clinicians to execute professional roles granted in fiduciary trust by states’ processes of credentialing and licensure. As John Stuart Mill argued long ago,²³ government can justifiably **limit individuals’ liberty** to prevent harm or to protect others’ liberty; liberty rights are not, nor should they be, absolute.

Overturning *Smith* would very likely do more harm to many than good to a few if it results in preventing people who are ill, injured, or otherwise vulnerable from accessing legal, clinically indicated, and publicly regulated health services. A post-*Smith* landscape would likely exacerbate health inequity. This implication deserves attention from all who make law, either through legislation or jurisprudence.

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Citation

AMA J Ethics. 2021;23(11):E864-868.

DOI

10.1001/amajethics.2021.864.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E869-874

POLICY FORUM: PEER-REVIEWED ARTICLE

Four Ways to Limit Use of Force in Care of Persons Experiencing Homelessness

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Abstract

Experiencing homelessness is traumatizing and can exacerbate mental illnesses and substance use disorders. When persons experiencing homelessness are a danger to themselves or others, petitioning for involuntary placement is clinically, ethically, and legally indicated. The process of involuntary commitment is often traumatic and can fracture already fragile relationships that persons experiencing homeless have; involuntary commitment should be used only when necessary. It is society's obligation to prevent crises but, when needed, to support persons in crisis by responding with care to their health needs.

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Mental Illness and Homelessness

There are complex, multidirectional relationships among homelessness, mental illness, substance use disorder (SUD), and trauma. Serious mental illness (SMI) and SUD can compromise patients' insight, perception, cognition, and behavior in ways that make it difficult for them to maintain housing, employment, and relationships. Both financial and behavioral implications of SUD can lead to homelessness,¹ and those who experience the trauma of homelessness often use alcohol or drugs to self-medicate.² One study showed that up to 68% of persons experiencing homelessness in childhood reported 4 or more adverse childhood events.³ Chronic injuries from physical trauma, such as traumatic brain injury, can generate cognitive and behavioral deficits, which also contribute to homelessness.⁴ Lack of affordable housing, loss of public support, SMI, SUD, or trauma history increase the likelihood that a person will experience homelessness.⁴ Deinstitutionalization during the US civil rights era also contributed to an epidemic of homelessness among persons with SMI,⁵ whose health is compromised by lack of community housing and rehabilitation policy and overreliance on incarceration for housing.⁵ Upstream, not downstream, resources need to be integrated into the health care system to address health, food, and shelter needs of persons experiencing homelessness.

Homelessness increases marginalization and decreases access to health care services.⁶ Meeting day-to-day survival needs (eg, food, shelter, hygiene) can delay health care seeking. Even when health care is accessed, medications can be lost or stolen or an individual's capacity to manage some side effects of medication can be compromised by housing instability. Access to medication is also compromised when insurance or employment is lost or when an individual's ability to **renew Medicaid** is undermined by not having a stable location for receipt of documents. Untreated and undertreated SMIs have devastating effects on persons experiencing homelessness. Suicidal ideation is 10 times more common among people experiencing homelessness than in the general population.⁷ Hospitalizations for SMI and SUD are almost 3 times as frequent among persons without than with stable housing (52% vs 18%).⁸

Involuntary Health Interventions

Persons experiencing homelessness are more likely to be involuntarily committed, a process that is chaotic and traumatic, exemplifies loss of control, and contributes to negative encounters with health care organizations and professionals. The American Psychiatric Association describes a person for whom involuntary interventions might be indicated as follows⁹:

- A person who has a severe mental disorder that “substantially impairs” thought, emotional process, judgment, or perception of reality or that “substantially impairs” behavior.
- A person who is in need of treatment in order to prevent relapse or deterioration that would cause the person to become a danger to themselves or others or to become unable to care for themselves.
- A person who, because of their mental illness, is unlikely to voluntarily seek or adhere to treatment.
- A person who has been committed to a mental health facility in the past 2 years who has not been able to adhere to treatment on their own on more than 1 occasion.
- A person whose condition is likely to improve with a well-planned, monitored course of treatment.
- A person for whom the clinician responsible for treatment has agreed to accept the patient and treatment plan.

Most commonly, people are not petitioned until they meet the standard of being a danger to self or others—that is, they are actively suicidal or homicidal with a plan, intention, and means, or they are unable to keep safe (eg, are unsheltered in subzero temperatures with inadequate clothing and protection or are prevented from seeking shelter by disorganized thoughts, perceptions, and delusions). Although homelessness alone is not a reason to involuntarily commit someone, being a danger to self or others warrants involuntary petition regardless of housing status.

There are times when clinicians have no option but to petition for involuntary outpatient or inpatient care to keep a patient or others safe. It is at such times that committing a person by force can be the **most compassionate** thing to do for a patient. However, since involuntary commitment is a kind of force commonly used in health care, this decision must be carefully deliberated upon by an admitting clinician. A decision to use interventions that limit the liberty of a person whose agency and options are already restricted by homelessness can cause that person to distrust the health care system

even more, especially when that person refuses care. Clinicians can be tempted to assume that such patients, especially those with SUD or those who make decisions against clinicians' advice, do not have decision-making capacity,¹⁰ but this is not always the case. People experiencing homelessness are consistently let down by resource-strapped health care systems. When patients have no surrogate decision maker or are otherwise unrepresented, as can be the case for persons experiencing homelessness who lack decision-making capacity, clinicians are ethically obligated not only to minimize the harms of using force (eg, trauma, humiliation, undermined self-determination),¹¹ but also to respond to patients with compassion and regard for their dignity in order to preserve the therapeutic capacity of the patient-clinician relationship. Clinicians should consider that committing a patient by force to optimize the patient's condition can also improve the patient's capacity for autonomous decision making.¹² While patients are being treated for their condition, force can be used to change medication regimens or other aspects of their care that make them unable to make decisions for themselves.

Four Ways to Meet Needs

Low-barrier, comprehensive, prevention-based interventions and shelter for persons experiencing homelessness are in short supply. Better alignment of food and shelter agencies' services with health care can help persons experiencing homelessness manage their illnesses and cope with numerous stresses and can prevent acute exacerbations of mental illness and crises that tend to lead to involuntary interventions' need and use in the course of care. Services should be trauma informed and integrated. While harm reduction has long been the standard of care, care should be delivered with compassion. Compassionate care can improve outcomes by enhancing autonomy, aligning with patients' values, and maintaining patients' long-term engagement in care.¹²

Training shelter staff in wellness. Although they are not often identified as such, shelter staff members are frontline health care workers, and community health workers and case managers have lived experience with caring about and for people experiencing homelessness.¹³ Providing shelter staff and street outreach workers with the basic tools to respond to food, shelter, hygiene, and health needs is critical. Programs such as Mental Health First Aid,¹⁴ Handle with Care®,¹⁵ and Crisis Prevention Institute¹⁶ are models of integrated care coordination.¹⁷ The more shelter staff seek to meet the physical and behavioral health of needs of individuals they serve, the better positioned will be organizations to advocate for the policy-level interests of persons experiencing homelessness.

Trauma-informed care. Trauma-informed care recognizes the health influences of trauma throughout the lifespan. Frontline health care workers should be educated in trauma-informed, patient-centered care that incorporates safety, choice, collaboration, and peer support to help avert crises.¹⁸

Compassion maximization, not just harm reduction. Harm reduction is not only relevant in cases in which care of a patient requires forced intervention; it is also a public health approach to minimizing population-based negative health outcomes. Harm reduction interventions (eg, needle exchange programs, naloxone, condoms, safe use sites, low-barrier shelters), along with improving food availability and choice and meeting basic comfort needs, are foundational to compassion, equity, public health, and good patient care. Harm reduction interventions keep people alive, engage them in services, and prevent destabilization¹⁹ and thus must be expanded to support clinicians',

organizations', and professions' obligations to express compassion to persons experiencing homelessness. While forcing treatment can lead to improved outcomes, it must be done with compassion and communication. These 2 variables are key to adherence to health care treatment plans, trust between clinician and patient, and patient autonomy.¹²

Care coordination. The programs named above involve teams offering services that help connect patients to programs for housing, mental health care, primary care, and medication-assisted treatment for SUD. Often referred to as "wrap-around" services, these services, when well coordinated, support patients' autonomy, reduce the likelihood of the need for involuntary interventions, contribute to housing stability, and promote wellness.²⁰

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Citation

AMA J Ethics. 2021;23(11):E869-874.

DOI

10.1001/amajethics.2021.869.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E875-880

POLICY FORUM: PEER-REVIEWED ARTICLE

How Medicaid and States Could Better Meet Health Needs of Persons Experiencing Homelessness

Sana Charania

Abstract

An estimated 580 000 people experienced homelessness on any single night in the United States in 2020. This article argues that, to address these persons' unmet needs, Medicaid should collaborate with clinicians and state programs to provide permanent supportive housing and housing support services to individuals experiencing homelessness. Access to shelter can improve health outcomes for individuals experiencing homelessness and reduce overall health care costs.

Housing and Health

The US Department of Housing and Urban Development defines homelessness as an individual or family lacking a fixed, regular, and adequate nighttime residence.¹ Although homelessness decreased in the United States by 12% from 2007 to 2019,² in 2020, an estimated 580 000 individuals still experienced homelessness on any given night.³ Most (61%) stayed in sheltered locations, while others (39%) remained unsheltered (eg, lived under bridges or in cars).³ In January 2020, roughly 25% of individuals experiencing homelessness (110 528 people) had “chronic patterns of homelessness,” experiencing homelessness continually for a year or more or experiencing at least 4 episodes of homelessness during the last 3 years.³

People experiencing homelessness have unmet health needs. On a given night in January 2010, 26% of sheltered persons experiencing homelessness had a severe mental illness and 35% had problems with substance use.⁴ More generally, homelessness is associated with poor health outcomes (eg, shorter life expectancy, higher usage of acute hospital services, and higher mortality and morbidity).^{5,6} An estimated 80% of emergency department visits made by individuals experiencing homelessness are for preventable illnesses that could be far more efficiently and effectively managed from both cost and health perspectives.⁷

Medicaid Expansion

The COVID-19 pandemic has exacerbated the US homelessness crisis. In 2020, homelessness increased by 2% over 2019.³ Millions of Americans, especially those with low incomes, have lost employment or are working reduced hours due to the pandemic; many are at risk of eviction when state moratoriums expire now that the federal

moratorium has expired.⁸ Given homelessness' association with costly care and poor outcomes, clinicians, organizations, insurers, and other health sector stakeholders have **ethical responsibilities** to motivate Medicaid expansion.

Under the Patient Protection and Affordable Care Act of 2010, 38 states and the District of Columbia adopted Medicaid expansion and increased health insurance coverage to individuals with annual incomes at or below 138% of the federal poverty level.⁹ This law also increased health care coverage among individuals experiencing homelessness: individuals experiencing homelessness with Medicaid coverage jumped from 45% in 2012 to 67% in 2014 in states that expanded Medicaid and only increased from 26% in 2012 to 30% in 2014 in states that did not.¹⁰ For newly covered individuals experiencing homelessness, Medicaid expansion delivered a pathway to secure needed health services.¹¹

Medicaid Expansion and Housing

Because Medicaid can cover certain-housing related services, Medicaid expansion can also increase access to housing support services and permanent supportive housing and help recipients secure employment and income.^{12,13} Permanent **supportive housing** is an effective intervention for improving health outcomes for individuals experiencing chronic homelessness and for decreasing overall health care costs,^{13,14,15} since it provides long-term affordable housing and needed services (eg, employment assistance, mental illness treatment, and substance use disorders treatment interventions).¹⁵ A study in Oregon reported a 55% reduction in Medicaid costs 1 year after individuals experiencing homelessness received permanent supportive housing.¹⁶ Another study in Chicago found that providing transitional and long-term housing to individuals experiencing homelessness led to a 29% reduction in hospital days and a 24% reduction in emergency department visits.¹⁷ Similarly, a program in New York State that provided 2300 supportive housing units and housing support services for individuals experiencing chronic homelessness¹⁸ reduced the average number of inpatient days and emergency department visits over a 12-month period.¹⁹ The program also reduced average Medicaid costs by \$9526 per person over a 2-year period.²⁰

Yet health insurance under Medicaid is not enough to meet the health needs of individuals experiencing homelessness. The high burden of chronic disease and disability among individuals experiencing homelessness, as well as lack of stable housing that can limit access to healthy foods and make it difficult to adhere to recommended interventions, is a significant obstacle for members of this population and those who care for them.²¹

Given Medicaid's provision of health insurance to many individuals experiencing homelessness, state Medicaid programs have incentives to provide housing-related services and collaborate with supportive housing programs to improve health outcomes and decrease costs of care for this population. In 2015, the Centers for Medicare and Medicaid Services released an informational bulletin stating that, under 1915(c) home and community-based service waivers, Medicaid funds can be used to help individuals prepare for and transition to housing, help identify and secure housing options, and provide services to help individuals be successful tenants.²² Medicaid funds can also support behavioral health and substance use interventions²² and some transportation expenses.²³

State Laboratories

Some states, such as Oregon and Louisiana, have waivers to support Medicaid beneficiaries with housing services, such as search assistance, eviction prevention, and care coordination among clinicians in primary care, mental health, and dentistry.^{12,24} For example, in 2005, the Louisiana Department of Health and the Louisiana Housing Authority created the Permanent Supportive Housing Program in response to hurricanes Katrina and Rita.¹² Housing was funded through federal low-income housing credits and disaster recovery funding. Most individuals and families supported by these programs were Medicaid beneficiaries, so Louisiana used Medicaid funds to cover some of these individuals' and families' costs of pre-tenancy, move-in, and ongoing tenancy services. Since its initiation in 2008, the program has had a 94% retention rate and led to a 24% reduction in average monthly Medicaid costs per person that demonstrates the key health benefits to individuals and families whose Medicaid benefits were applied to cover tenancy support services.^{12,25} Hawaii also gained approval to use Medicaid funds for housing services,²⁶ and it introduced a bill that would classify chronic homelessness as a key health determinant to direct some state Medicaid funds to secure beneficiaries' housing.²⁷ Research on such initiatives can continue to motivate better understanding of the health benefits of applying insurance benefits to housing services.

Clinicians' and Organizations' Roles

Medicaid can't resolve homelessness alone. Clinicians, like members of the general public, hold implicit or unconscious biases about socially stigmatized groups, including individuals experiencing homelessness. Since bias **can influence diagnoses** and intervention recommendations and exacerbate inequity,^{28,29,30} clinicians and students must first be trained to identify and mitigate its influence on clinical and ethical decision making. Second, clinicians should see clinical encounters with patients as opportunities to assess and address social determinants of their patients' health. Only 24% of hospitals and 16% of physician practices nationwide reported screening patients for basic health security (eg, food access, housing instability, and exposure to violence).³¹ Such health information is needed to understand patients' health risks; to contextualize their **capacity to adhere** to health recommendations; to modify interventions to be helpful, useful, and responsive to patient vulnerabilities; and to facilitate patients' connections with resources (eg, shelters, community centers, food pantries, and state and federal welfare programs).^{32,33,34,35} Third, clinicians can direct individuals experiencing homelessness who qualify for Medicaid to enroll. One study of 725 adults experiencing chronic homelessness in 11 cities found that almost 75% of Medicaid-eligible individuals were not enrolled in the program.¹¹ State Medicaid programs can support clinicians' and organizations' efforts by incentivizing and standardizing relevant data collection and use to facilitate research about program quality in motivating health outcome improvements among persons experiencing homelessness.³⁶

State Medicaid programs should collaborate with key supportive housing programs to better leverage health care infrastructure to serve people with complex clinical, behavioral, and social needs and to apply best practices to care of individuals experiencing homelessness.

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Citation

AMA J Ethics. 2021;23(11):E875-880.

DOI

10.1001/amajethics.2021.875.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E881-886

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

How Should Street Medicine Clinicians Interact With Law Enforcement Officers?

James S. Withers, MD and Eleanor Kotov, MD

Abstract

Street medicine clinicians and law enforcement officers share a common challenge. Both are frontline professionals positioned at the interface of large, inflexible systems and those experiencing street homelessness. Both professions face difficult challenges as they attempt to work with a population struggling with complex issues. That complexity can be magnified when their work overlaps. Yet little has been written to guide professional conduct in this overlapping terrain. This article will discuss how street medicine clinicians might fulfill their ethical duty to those in their care when interacting with their counterparts in law enforcement.

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Background

Street medicine^{1,2} is a relatively new medical field in which clinicians visit people living in camps, along riverbanks, in alleys, and in abandoned buildings. Essentially, clinicians make “house calls” to those who are experiencing street homelessness. This form of medicine addresses gaps in care and fulfills physicians’ ethical duty to provide equal care for all.³ Typically, street medicine clinicians sit with rough sleepers by their fires, on the pavement, or at other location for hours to listen to and understand the reality of those they serve. By starting the health care relationship outside the traditional structure of the health care system, street medicine clinicians are able to **gain trust** and solidarity with those on the streets. Much of the structural violence of the systems-centered encounter is avoided, and it becomes possible to rehumanize all involved. Relationships in which the patient is the subject, not the object, of their own healing narrative evolve organically.

Street medicine clinicians witness the profound alienation that those experiencing homelessness endure on a daily basis. It is common to hear rough sleepers say, “I’d rather die than go to the hospital.” This attitude stems from rough sleepers’ experiences of disrespect and a feeling that their issues are not taken as seriously by those in the “system.”⁴

When street medicine clinicians encounter first responders, they sometimes witness the disrespect that their patients describe. Overworked, frustrated staff can close ranks and treat those experiencing street homelessness with real hostility.⁵ This conduct may rightly be seen as a betrayal of professional ethics but also as a symptom of how first responders, such as law enforcement officers, are trapped in an often-thankless position. One paramedic in Santa Barbara, California, said, “I hate the homeless!” (who sometimes spat on her) but wanted to “work with them like *you* [street clinicians] do.” After becoming a street medicine volunteer, she exclaimed, “I love these people!” She was the same decent person but was now embraced by those on the streets as a friend rather than just a person in a uniform.

Street medicine clinicians often witness interactions between those experiencing street homelessness and law enforcement. Officers are thrust into difficult situations when called to respond to incidents involving those experiencing street homelessness. These calls can be in response to a person in distress, but more often they are generated by a citizen or business that is alarmed by someone whose behavior or appearance is of concern. One study in San Francisco, California, found that there were 98 793 police dispatches for homeless complaints in 2017.⁶ Police officers have limited tools (arrest or citation), and their arrival can trigger aggression by retraumatizing those living on the streets. These interactions can escalate and result in injury or, rarely, even death.^{7,8}

Street Medicine and Law Enforcement

As clinicians who practice street medicine, we have found that one of the central challenges of practicing street medicine in the same terrain in which law enforcement operates is understanding the boundaries of our professional authority. Within an office or hospital, our medical roles and responsibilities are clear. We have a contractual and ethical framework that is supported by law and professional guidelines. Street medicine seeks to take those standards out into the rough sleeping community. Because law enforcement officers have their own authority that is well established on the streets, the 2 professions’ authority overlaps in this geographical space. Navigating that overlap requires both groups’ mutual respect, collaboration, and professionalism.

Street medicine clinicians typically encounter law enforcement when they are concerned about the safety of those they serve and dial 911. The majority of such calls (made by street medicine clinicians) are for ambulance transport to a local emergency medicine department. When using 911, it is important to give the dispatcher a concise account of the crisis and identify yourself as a medical professional within a street medicine organization. Typically, police and firefighters arrive before the paramedics. When officers arrive on the scene, it is best to respectfully introduce yourself, then step aside, staying close enough to be consulted. If there is serious concern for violence, the clinical team should retreat entirely from the scene as soon as possible. It is important not to create an adversarial relationship with law enforcement. Indeed, interactions are an opportunity to develop a better working relationship with law enforcement officers.

Street medicine programs can improve their collaboration with law enforcement by having program representatives formally meet with officers to explain their role and discuss how best to work in concert. Typically, police chiefs or commanders are able to frame these meetings so that officers understand their value and mutual respect can be established. When officers are able to explain their own work and challenges, they are much more likely to be open to collaboration with street medicine clinicians. Police officers have required trainings in **behavioral health** and community engagement when

street medicine representatives can join the faculty to provide information and explore the issues around homelessness more deeply.⁹ It is vital to get to know those individual leaders and officers who are willing to maintain collaborative relationships. Street medicine clinicians may witness specific human rights violations or systematic unjust conditions involving law enforcement. It is our moral and professional duty to address these injustices. It is appropriate to respectfully voice your concerns at the time. Individual instances should be documented in the same objective fashion that one would use in the medical record for other circumstances, such as intimate partner violence. Serious violations should be reported to the local Office of Municipal Investigations (OMI) or equivalent unit. This action has the advantage of bypassing early involvement of the police union, which can sometimes distort the investigation. Clinicians should support and counsel victims as they would any other patient. Street medicine programs should also have established relationships with legal services to assist victims and guide them through the legal process. Many programs have contacts with legal firms or with American Civil Liberties Union branches that are willing to take on such cases. Street medicine programs should join local committees addressing human rights violations and, if possible, facilitate those with lived experience to represent themselves to those in authority.

One recent development in street medicine has been the creation of formalized collaborations with law enforcement. These initiatives were largely generated by cities recognizing the need for mental health and social services when responding to crises on the streets in the wake of the Black Lives Matter movement. In Pittsburgh, for example, the Mayor's Office, county government offices, law enforcement, street medicine organizations, and a wide array of community stakeholders created the Allegheny County Crisis Response Stakeholder Group to improve how 911 calls are managed.¹⁰ As a result, a team approach is being developed in which dispatch services can call upon mental health and street medicine clinicians to respond in tandem with police and other first responders.¹¹ Onsite teams will have the ability and discretion to divert appropriate individuals to mental health, shelter, and medical services in lieu of the criminal justice system. As the project becomes operational, the results will be monitored to improve effectiveness.

The Liminal Space

A full discussion of the interface between law enforcement and street medicine is beyond the scope of this article. An examination of the liminal space between street clinicians and law enforcement, however, may help elucidate the ethical duty of the street clinician. For example, the most difficult and controversial situations arise when street medicine clinicians anticipate that calling the police might lead to a potentially dangerous escalation. It might be best in those cases not to call 911. Let us examine 2 examples.

Several years ago, in a suburb of Pittsburgh, the police were called to remove an intoxicated male known to be experiencing homelessness. When confronted, the man refused to cooperate and was warned that he would be tasered. He again refused to cooperate and was tasered repeatedly, but this action was not effective due to his layers of jackets. At this point, the officers threatened to release their police dog, which prompted the man to declare that, if so, he would kill the dog. The dog was released, and the man stabbed and killed the dog. At this point, officers pursued the man and shot him multiple times, killing him.¹²

More recently, a highly experienced street clinician and his team in Charleston, South Carolina, encountered 2 men they knew who were arguing. They were standing at a distance, both were drunk, and one had a small knife. One of the team members suggested they call the police, but the team leader determined that it would be better to deescalate the situation themselves. They were able to redirect both men and avoid involving law enforcement. Later, the team leader (who had good relationships with the police) shared his story with an officer who thanked him for handling the situation as he did (A. Woods, medical director of Charleston Street Health, oral communication, 2020).

Clearly, these examples are complex. The central issue in both is **the exertion of control**. In the first example, the rigid application of control had disastrous consequences. The second example centers on the ethical question of whether to exert control in what would be considered “street business” by involving the police. The team made the difficult decision to use their relationship skills instead. The basis of relationships on the streets depends on respecting the autonomy of those served. The same principle applies to working with people as they inject or even sell illegal substances. Law enforcement has no such option and therefore cannot achieve the same therapeutic relationships. It is an ethical obligation for street medicine clinicians not only to maintain trust, but also to work with law enforcement when necessary to protect those living on the streets.

Conclusion

Both law enforcement and street medicine are crucial to the well-being of those experiencing street homelessness. Each offers vital services that the other cannot provide to those in need. To date, there are few studies that explore street medicine best practices for interprofessional interactions, and more are needed. If effective collaborations between street medicine and law enforcement can be established, it would particularly benefit African American, Native American, and Latinx persons, who are overrepresented on the streets and who have experienced significant tension with law enforcement. Participatory research to identify ethical practices that reflect the voice and the needs of those living on the streets is also vital. If we can create a healing environment for those on the streets in partnership with law enforcement, we may set an example for the greater social healing our communities need.

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Citation

AMA J Ethics. 2021;23(11):E881-886.

DOI

10.1001/amajethics.2021.881.

Acknowledgements

The authors would like to acknowledge and thank Officers Stephen Vinansky (Pittsburgh Police) and John Tamuschy (Allegheny County Police) for their confidential discussions on the subject matter.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E887-892

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Home Health Care for Patients Without Shelter

Sunil R. Dommaraju, Vanitha Raguveer, Clara Ryan, MS, Justin Ceh, MD, William L. Galanter, MD, PhD, and Evelyn Figueroa, MD

Abstract

Home health care (HHC) is a well-established model of caring for patients in their homes, which has not been robustly applied to benefit patients without regular access to shelter. This article describes Chicago Street Medicine, an organization that implements HHC to improve health outcomes and care continuity for patients experiencing homelessness.

Home Health Care

Home health care (HHC) delivers a wide range of services directly to patients in their homes, including nursing care, physical and occupational therapy, and social services.¹ Historically, HHC allowed sick patients to receive routine care where they resided. In the 19th century, health service organizations began sending nurses to homes of patients experiencing poverty or chronic illness, ushering in new health insurance models.² With the COVID-19 pandemic, HHC evolved again, integrating telehealth visits with patients in their homes. The Centers for Disease Control and Prevention reported a 154% increase in telehealth visits during the last week of March 2020 compared to that same week in 2019.³ Some organizations still de-emphasize the advantages of HHC,⁴ but caring for elders and patients recovering from acute illness or injury are common HHC practices in the United States today.⁵ HHC can reduce barriers to health care access and provide comprehensive, socially informed care to **patients without shelter**, some of whom consider the streets to be their homes.

Home Health for Patients Experiencing Homelessness

Context. The current US health care system prioritizes sickness over proactive health maintenance practices.^{6,7} But this approach offers no incentive to make care accessible to patients experiencing homelessness, whose barriers to care range from stigma to lack of insurance.⁸ Episodic emergency care neglects the social circumstances and basic needs of unsheltered patients,⁹ who have higher emergency department utilization than sheltered patients who are homeless and higher hospital admissions and readmissions than housed patients due to their lack of access to consistent primary care.^{10,11,12} Consequently, housing instability is a predictor of negative health outcomes, with patients experiencing homelessness nearly 10 times more likely than sheltered

Medicaid patients to return to an emergency department 6 months after an initial visit,¹³ placing increased burden on the health care system overall.

Benefits. In a cross-sectional study of US hospitals, only 24% of patients experiencing homelessness reported regular screening for housing and food insecurity, demonstrating a devastating lack of holistic care.¹⁴ In HHC, however, clinicians, seeing unsheltered patients where they reside (eg, a tent, mattress, or underpass), become acutely familiar with risks unsheltered patients face and observe their domestic and social relationships, enabling contextualization of their care plans.¹⁵ Contextualized care plans emphasize patients' experiences. In one study evaluating the relation between favorable health outcomes and contextualized plans of care, 71% of patients had positive outcomes when their care plan was contextualized vs 46% when it was not.¹⁶

Finally, bringing care to the streets strengthens health care workers' ability to engage in shared decision making (SDM) with patients experiencing homelessness, since patients may feel safer and more autonomous in their home environment. SDM, applied in venues like patient-centered medical homes, helps patients actively engage in their health decision making.^{17,18} In addition, trust between physicians and patients is found to be an independent predictor of successful SDM,¹⁹ and, unlike traditional models of care, HHC allows for true social bonding in a familiar environment. Especially in the setting of chronic illness and when intervention involves multiple encounters, SDM is an effective model to achieve treatment agreement and adherence.²⁰

Barriers. Despite the numerous advantages of the HHC model, it presents some limitations. Logistically, health practitioners would require further training on how to provide care in an unknown environment. Additionally, given that Medicaid reimbursements are already restrictive, the need to enroll many individuals experiencing homelessness in Medicaid might discourage clinicians from participating in the Medicaid program.^{21,22} Even if these problems could be overcome, continuity of care and integration of HHC into the larger health care system pose challenges for the HHC model. Follow-up care can be difficult, since individuals experiencing homelessness often migrate throughout the city and lack a permanent address. Integration requires coordinating HHC with care provided through health care systems using electronic health records and documentation. Finally, HHC models must make considerable effort to establish connections to social support programs, which are linked with successful health outcomes.²³

Chicago Street Medicine

Chicago Street Medicine, a nonprofit, student-run organization based in Chicago, Illinois, provides a robust example of how HHC can be applied in the care of patients experiencing homelessness. According to the City of Chicago point-in-time count, in 2020, there were 5390 people experiencing homelessness in Chicago. Of these, 38.1% were female, 61.6% male, and 0.3% transgender.²⁴ Black people composed 77% of this population and White people, 20.2%.²⁴ Finally, 21% of the population were under the age of 18, and 10.2% were over the age of 60.²⁴

In tandem with the rise of **street medicine programs** across the United States, Chicago Street Medicine (CSM) was founded in 2017 by students and residents at the University of Illinois College of Medicine (UIC) to serve the unsheltered population.²⁵ The organization has since grown into a multidisciplinary 501(c)(3) nongovernmental organization²⁵ that operates through chapters at UIC, University of Chicago, Rush

University, and Northwestern University. CSM's mission is to provide medical and social services to homeless communities in Chicago "on their terms, on their turf."²⁶ The mission emphasizes meeting patients experiencing homelessness where they are, both geographically and medically, and reinforcing their autonomy in decision making. CSM collaborates with numerous community partners, including clinics like Mile Square Health Center, a federally qualified health center (FQHC). FQHCs like Mile Square help reinforce continuity of care by reserving appointment times solely for CSM patient follow-ups.

The crux of CSM's work is street runs conducted by CSM's team of medical students, social workers, occupational therapists, dental students, medical residents, and attending physicians, who address the health care needs of and **establish rapport** with people living on the streets of Chicago. This team of street-run volunteers, usually 4 to 5 people at a time, triage and plan care, which often constitutes taking a basic medical history, prescribing medications, and making health care referrals. Volunteers also provide food, over-the-counter medications, hygiene products, and clothing. The food is supplied through local partnerships with pantries, and other supplies are donated or purchased. Street runs at the UIC chapter occur once a week on Thursdays from 6 pm to 9 pm and once a month on Sundays from 6 pm to 9 pm.

Most volunteers have a strong interest in trauma-informed care—that is, in sensitively and intentionally addressing the possibility of past trauma in patients in an equitable manner. Many volunteers have an established relationship with patients, making it easier to aptly listen to their concerns. Volunteers work to ensure that people feel safe in conversing about sensitive topics like drug use and sexual history that are crucial to health care. As the third author (CR) has remarked, "I can't even count the number of times people went out of their way to stop, stare, and scoff at the members we worked with ... be kind..." By building trust through social bonds, patients become more willing to collaborate with medical practitioners.²⁷

While some might argue that HHC in the form of street medicine could become disconnected from traditional health care systems, CSM strives for continuity of care. Recently, CSM implemented an electronic medical record (EMR) system using athenahealth to track continuity of care. CSM also formally joined the Chicago Continuum of Care, a group of more than 100 organizations that systematically strategizes provision of services and housing for people experiencing homelessness. CSM does not currently have data on how many patients have continuity of care or robust data on the specific demographics its teams serve; however, the combination of an EMR system and coordination with other Chicago service organizations will improve efforts to document and track patients and to set monthly and yearly goals to measure success.

Conclusion

HHC, especially in the form of street medicine, focuses on patients' experience, inviting caregivers to understand patients' medical needs in their sociocultural context. Such insight is invaluable in strengthening community relationships and bridging cultural divides that bias patient care. The rise in telemedicine has revitalized the HHC model, encouraging insurers, clinicians, and patients to adapt traditional health care models,²⁸ which often center service within the 4 walls of a clinic or hospital.²⁹

Adoption of the HHC model could fundamentally improve the health care system and uplift historically marginalized populations, such as patients experiencing homelessness. In practice, CSM's innovative version of the HHC model has potential to deliver COVID vaccines to at-risk patients experiencing homelessness who may not have confidence in a traditional health care system. As the medical community works to envision a future of equitable access to health care, it is imperative that innovative, human-centered health care delivery models, such as street medicine programs, be enveloped within the broad spectrum of medicine.

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Citation

AMA J Ethics. 2021;23(11):E887-892.

DOI

10.1001/amajethics.2021.887.

Acknowledgements

Thank you to Chicago Street Medicine and all who care for people experiencing homelessness. Clara Ryan, an invaluable member of our street-run team and coauthor, recently died. We honor her memory, kindness, and dedication to the dignity of all persons with whom "we share this city."

Conflict of Interest Disclosure

The author(s) had no relevant conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

November 2021, Volume 23, Number 11: E893-897

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

How Bodily Integrity Is a Core Ethical Value in Care of Persons Experiencing Homelessness

Jennifer Markusic Wimberly, MD, MA and John Z. Sadler, MD

Abstract

Influences of chronic homelessness on patients' conceptions of bodily integrity can conflict with clinicians' recommendations about clinically indicated interventions, such as dialysis or amputations. This article considers such conflict by drawing on a capabilities-based model to reframe health care as shared between a patient and clinical team.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ available through the AMA Ed Hub™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Body as Home

An individual experiencing chronic homelessness is a person with chronic disability who has “been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven for the last 12 months continuously or on at least four occasions in the last three years *where those occasions cumulatively total at least 12 months.*”¹ Such persons compose 24% of the US homeless population at any given time.² As with other social determinants of health, homelessness disproportionately affects racial and ethnic minorities.³

People experiencing homelessness, like all of us, have many values and beliefs that shape health decisions. Chronic homelessness, however, often reduces access to and the availability of interventions and exposes patients to increased risk of robbery and assault.⁴ Constrained by these circumstances, the choices of patients experiencing homelessness can conflict with clinicians' everyday assumptions about reasonable, ethical care. There are also logistical and practical barriers to care continuity, which tend to compound when **patients refuse interventions** or don't adhere to clinicians' recommendations. When clinicians' recommendations force individuals experiencing homelessness to choose—for example, between housing that minimizes vulnerability by enhancing safety, security, and freedom of control of their own environment and bodily integrity that increases vulnerability—patients tend to feel subject to others.⁵ Clinicians should be aware of their capacity to unintentionally exacerbate this kind of vulnerability often felt by patients experiencing homelessness.

Instead of considering the individual experiencing homelessness as noncompliant, nonadherent, or treatment refusing, we intend to reframe the care of persons experiencing homelessness as a shared endeavor between clinician and patient. This reframing involves clinicians' attention to the interdependence among core capabilities and values—such as bodily integrity and avoidance of vulnerability and material loss—that might conflict with the core capability of health and well-being. Considering the interplay of capabilities is a means of enriching the **decision making** of individuals experiencing homelessness and can support better outcomes when individuals experiencing homelessness are presented with the ethical challenge of body-altering medical treatments. Shared decision making based on individuals' broad capabilities enables individuals to pursue a life in accordance with what they are actually able to do and thereby to flourish.⁶ In what follows, we utilize Martha Nussbaum's capabilities approach⁵ to analyze the conditions for flourishing of individuals experiencing chronic homelessness, given their extraordinary circumstances and adaptive challenges.

Capabilities

Nussbaum's 10 core capabilities are categorized as follows: life (preserving a normal life span); bodily health; bodily integrity; senses, imagination and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment.⁶ Here, we focus on bodily integrity and trade-offs among bodily integrity, preserving life, and control over one's environment (or, rather, freedom from unwarranted interference).⁶

Bodily integrity. Given that individuals experiencing chronic homelessness also have chronic disabilities, their bodily integrity becomes a core capability of immense importance. Rae Johnson⁶ describes the homeless body as a de facto "home." We argue that the homeless body as "home" to the self amplifies the importance of the body over and above that of the domiciled self. The body is valued as sacrosanct, worthy of defense against violation. The "body as home" underpins the profound need for the individual experiencing homelessness to maintain, even elevate, Nussbaum's core capability of bodily integrity. The capability of bodily integrity is a strong driver of loss aversion, and avoidance of vulnerability enables 2 other core capabilities, according to Nussbaum: freedom from unwarranted interference and preserving a normal lifespan.⁷ Yet clinical recommendations that affect bodily integrity can compromise other capabilities, thereby affecting the opportunities the individual has to achieve independence and control of their personal environment—the de facto body as home.^{7,8}

Trade-offs. Consider the example of amputation that leaves one with a disability—for example, a lower limb loss requiring a wheelchair or prosthetic. For a domiciled individual, this is a major adaptation but not an ongoing threat to personal safety. However, for the individual experiencing homelessness, the loss of personal freedom through reduced mobility is profound, and the loss of safety from victimization is equally profound. Maintaining bodily integrity can promote freedom, safety, and security and respects the inviolability of the body for an unspecified time. The likely outcome of the refusal of amputation, however, might further reduce the lifespan of the individual experiencing homelessness. Yet such an individual's vision of the life well-lived⁵ might well include a lifespan that is shorter but free from vulnerability and undue loss of mobility. This is the same kind of trade-off regarding one's personal values that we would respect, say, in cancer patients who are willing to have a lifespan that is shorter but with more mobility and bodily integrity to pursue projects and personal relationships. Patients' trade-offs between their capability for bodily health and their capability for

bodily integrity with freedom from vulnerability is not routinely considered in ordinary care of the would-be amputee. The capabilities approach thus facilitates a realization of other values bearing on the amputation decision.

Capabilities and Caregiving

In addition to basic capabilities, Nussbaum proposes *combined capabilities* as a way to conceive of internal preparedness for flourishing combined with external conditions that do not impede the individual's flourishing. This readiness for flourishing within the capabilities approach is relevant to both clinicians and patients. Clinicians must be prepared to engage (psychologically and emotionally) with patients, as well as be positioned within a supportive environment, in order to engage effectively with patients and realize the ideals of shared decision making.⁷ For patients experiencing homelessness, the hospital has the responsibility to create a supportive environment to prepare the patient to engage in life-critical discussions that too often devolve into simple consent-refusal discussions rather than an examination and appreciation of distinctive values that are important to the patient. The traditional role of the physician as “captain of the ship” in the health care environment does not readily permit this kind of engagement,⁹ as care relationships are efficiency oriented and top-down.

Health decision making informed by a capabilities approach reduces the potential for physicians to act as captain of the ship and impose their values on patients experiencing homelessness. Although shared decision making is a widely endorsed approach to care decisions, for patients with **impaired decision-making capacity**, this approach has significant limitations, especially when suitable surrogates are absent.^{10,11} Consistent with Annette Rid and David Wendler's suggested use of a “patient preference predictor,”¹² which uses aggregate data based on patient characteristics to predict the preference of a given patient lacking decision-making capacity, the capabilities approach can help inform care decisions when clinicians appreciate the unique circumstances and preference for bodily integrity of individuals experiencing chronic homelessness.

Implementing a care plan that is not aligned with the personal values of a patient experiencing chronic homelessness will likely yield the result of recurring challenges to acceptance or adherence. Such tunnel vision misses the goal of medicine, or what Pellegrino calls “acting for the good of the patient,” which should be guided by the virtue of phronesis, or practical wisdom—that is, honoring right choice based on right reason with appropriate intent.¹³

Implementation

How might an engagement-supportive environment be facilitated? The clinician is wise to approach emotional and value-laden health care encounters with involvement of multiple expert members of the health care team, as well as the social support system of the patient experiencing homelessness, if available, to learn how best to meet that patient's health care needs in alignment with their core personal values and life choices. Team members, such as nursing staff, care managers, social workers, patient advocates, and psychologists, can provide a compassionate approach to assessing the individual in the context of their life circumstances. To negotiate a care plan that is clinically appropriate and optimal from the patient's perspective, clinicians must recognize that individuals experiencing homelessness need to be supported within their social environment.

Negotiating requires empathic listening in order to gain understanding of the unresolved issue, discover the individual's vision of a life well lived,⁵ and identify the needs of the individual to pursue such a vision. Such engagement likely will not be accomplished in a single visit by even the most capabilities-attuned clinician. The negotiation process is one of iteration.¹⁴ An iterative process to identify conflict among enabling and constraining core capabilities may promote the patient's self-determination to integrate core personal values with capabilities. This process permits individuals experiencing homelessness to engage in action aimed at the flourishing they are capable of attaining. Donald Berwick supports a call to action for clinicians to guide quality improvements in health care provided to the underserved.¹⁵ We strive to advance the health care capabilities of the individuals experiencing homelessness and advance Berwick's imaginative moral image of healers as guides to action.¹⁵

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Citation

AMA J Ethics. 2021;23(11):E893-897.

DOI

10.1001/amajethics.2021.893.

Conflict of Interest Disclosure

Dr Sadler reported receiving royalties from Oxford University Press. Dr Wimberly had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

MEDICINE AND SOCIETY

Summer Without Shelter in Tampa During COVID-19

Madeline J. Hooper, Lauren C. Linkowski, Lynette Menezes, PhD, and Jordan Messler, MD

Abstract

Shelter-in-place orders enacted during the 2020 COVID-19 pandemic were impossible to abide by for some persons without shelter in Tampa, Florida. This narrative considers themes of community, public health, and material conditions of humanity and dignity in a photographic investigation of life among persons for whom the prevailing adage “safer at home” did not apply.

Documenting Place and Health

The COVID-19 pandemic uprooted innumerable social and economic systems, including those supporting vulnerable populations. Quarantine measures limited the accessibility of food banks, shelters, and **free clinics**. Our neighbors experiencing homelessness had no home at which they could “shelter in place” when these guidelines were introduced. These realities exacerbated the health challenges such persons faced at baseline, including physical and mental illness, sleeping in congregate environments, and living without reliable access to safe shelter, food and water, and health care. Moreover, the nature of human relationships has been redefined by the pandemic: communities are distanced, and subsequent anxiety has proved to be as insidious as SARS-CoV-2.

Photographs are powerful tools for community reflection because they viscerally convey unique perspectives and experiences.^{1,2} Image-based studies can unpack complex relationships between place and health.^{3,4,5} During July and August of 2020, a man we’ll call Liam—an African American man in his 40s newly experiencing homelessness—was given a 28-exposure disposable camera to document his responses to the question: How have your life on the street and the COVID-19 pandemic affected your health? Here, Liam shares his story of living on the streets during a time of social upheaval.

Liam

I was once married and working with a place to call home. The marriage slowly fell apart in 2018 and by that time I was living with my parents. My father told me on New Year’s Day 2019 that I had to leave and that the “clock was ticking.” With no job prospects throughout the year, I was left with one option. I am now homeless with no family support. Not that I am on hard core drugs (I liked to smoke pot). I have severed ties with my parents and sister. Even with the current pandemic, you would think they’d come to

my rescue. While on the streets, I recently found God through some folks doing missionary work.

Figure 1. A Sidewalk in Tampa



This is where I sleep at night and congregate during the day with my newly adopted “family.” Most of us don’t have jobs. We joke around and have fun. Some of us drink and some smoke cigarettes and cigars. I myself was never a cigarette/cigar smoker, but the last 2 months out here in downtown have been stressful. In order to cope I have been smoking cigarettes and cigars.

Figure 2. “Shower and Empower”



Every 2-4 weeks Presbyterian Church offers showers to the homeless. It’s a small, mobile shed with 2 showers and a washing machine/dryer. You get a 10 min time limit,

so you have to move quickly. It provides a temporary solution to going without a daily shower. The list is very long. Somewhere between 25 to 45 people. I've done it twice, but it's so hot the freshness doesn't last that long. Although, it is refreshing.

Figure 3. Independence Day



On the 4th of July to the 5th wee hours someone rewarded us with KFC [Kentucky Fried Chicken]. It really came at a good time, most of us were still hungry. Simultaneously, another homeless individual brought me water and 2 slices of pizza.

Figure 4. Summer Cookout



One of our associates on Marion St brought back a box full of chilled/frozen food. At 10:45 at night we had no way to cook anything. Someone (myself) got the bright [idea]

to flip a cart on its side, add the burning fuel underneath, and cook on it on the cart grates. We did not have to do that as it turns out, one of the shopping carts had 2 tiers. We could light the fire on the lower tier and cook the food on the top tier. After starting the fire, officers in the parking lot noticed the flames rising out of control. They approached the makeshift hobo grill and 2 of my comrades. The grilled chicken came out a little warm with vegetables and cheese.

Figure 5. Curtis Hixon



This is Curtis Hixon Park. This is one of many places homeless people can charge their mobile devices. Other homeless people use it to consume illegal drugs. Some people use it to get drunk all day. Basically, Curtis Hixon is a sanctuary for the homeless during the daytime. Amidst COVID-19 and certain public buildings being closed the only place to seek cooler shading is the Tampa Bay Buccaneers Foundation tent. This heat wave has caused a lot of heat strokes due to lack of cool water. The only restaurant providing cool, free ice water is Four Green Fields. The staff for the most part has been quite generous.

Building Community Consciousness

Liam's photo narrative illustrates that the human experience of COVID-19 has been as universal as the coronavirus itself. In "A Sidewalk in Tampa," Liam shares how he coped with the synergistic stresses of homelessness and the pandemic—psychological burdens shared by many as the social effects of COVID-19 persist. Public parks, as depicted in "Curtis Hixon," also epitomize the community spaces and connections lost to the pandemic. Yet parks also symbolize the dissonant experiences different populations have faced since January 2020. Although playgrounds for some, parks are crucial lifelines for persons experiencing homelessness. As they deprived us of normal community practices, pandemic **quarantine policies** emphasized the importance of belonging for many; however, social distancing reinforced the dehumanizing effects of social exclusion for marginalized groups. While the daytime scene of "A Sidewalk in Tampa" conceals the nighttime camaraderie Liam shares with his "adopted family," the

practice of visualizing Liam and his friends' socialization is crucial to humanizing homelessness.

Moreover, COVID-19 elucidated myriad ironies and inequities of the “support systems” established to support at-risk populations. “Shower and Empower” and “Independence Day” are poignant examples of this unveiling. The blue color in the former is bright in its promise of cool refreshment, a reprieve from Tampa’s smothering humidity. Simultaneously, we are compelled to ask if a rushed 10 minutes for personal care is truly empowering. Then consider the paradox of an unsheltered Black man receiving a “reward” of a KFC bucket on the Fourth of July. Smiling up at the camera in “Independence Day” is Colonel Sanders, KFC’s mascot in the style of its founder, Harland Sanders, a running mate candidate of Alabama segregationist George Wallace in his 1968 presidential campaign.⁶ Contextualizing this image within the summer of 2020—hot with domestic and global turmoil that was amplified by George Floyd's murder and its consequences—imparts the gravity of how the year’s provocations and tensions further destabilized the lives of vulnerable populations.

Top-down misunderstanding of community members’ needs is further exemplified by the shopping cart-qua-grill story depicted in “Summer Cookout.” Some well-intended gifts (in this case, frozen food) reveal fundamental misapprehension of actual need. This tension is captured in the contrasting symbolism of “Summer Cookout.” Even though the man in the photo is “grilling,” a quintessential American summer pastime, the enthusiasm of the grocery store ad denoting “Summer is here” feels out of place on the dark street corner.

Furthermore, the communal vodka in “Summer Cookout” contrasts with efforts to minimize COVID-19 transmission. Throughout 2020, face covering mandates were introduced across the country; such an order was implemented in Tampa in June 2020.⁷ Although a necessary public health measure, mask mandates compounded the ostracization of homelessness because of access, affordability, and education inequities. While masks quickly became symbols of public conscientiousness and personal virtue in many circles, they exacerbated the invisibility that blankets homelessness. A face covering ostensibly dehumanizes its wearer because we cannot appreciate their full personhood. This phenomenon disproportionately affects the well-being of vulnerable individuals compared to that of more integrated and accepted members of society.

Liam’s photo narrative reveals the importance of the plurality of experience within our communities and reflects the inadequacy of our public health infrastructure. His reflections illuminate the opportunity that exists to improve the **health care** we provide to vulnerable populations: care frequently overshadowed by flashier innovations and expansion.

Social Distance, Exclusion, and Support

Communities have been dismantled by COVID-19 social distancing requirements, leaving their members lonely and deprived of human interaction. Now, we face questions about how to strengthen our community partnerships and service delivery streams. How can we address social exile and socioeconomic exclusion as negative health effects of infection control? How can we reimagine city infrastructure to better support the health of the entire local population? How can community members support one another—including persons experiencing homelessness—from a distance of 6 feet?

Embracing “nothing about us without us”⁸ can help nourish empathic relationships and improve health care for patients across all social strata, during and after the pandemic.

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Editor's Note

This study was reviewed by the University of South Florida Institutional Review Board and approved on February 21, 2020.

Citation

AMA J Ethics. 2021;23(11):E898-904.

DOI

10.1001/amajethics.2021.898.

Acknowledgements

The authors would like to thank the Arnold P. Gold Foundation for its support of this project through the 2020 Gold Student Summer Fellowship (L. Linkowski and M. Hooper).

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.