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PROFESSIONAL ISSUES

Treating the homeless can go beyond medical care

What duties does a doctor have to a homeless patient who repeatedly visits the ED?

Scenario:

George, 57 and homeless, walks into your emergency department for the second time this week. He reports that the "swelling" on his arm has not improved, despite a prescription for Bactrim from the same ED seven days earlier. He describes a new cough and sore throat and reports twinges of chest pain. He also says that he took the prescription for three days, but had to stop when his backpack and the medication were stolen. A recent inpatient cardiac workup was negative. The furuncle on his arm is drained and new oral antibiotics given; all other workup suggests absence of acute medical illness. The overnight low temperature will be 38 degrees. George complains that eight hours in the ED without getting a meal could be grounds for a lawsuit. As you bring him a seven-day course of antibiotics and discharge papers, he says, "I could be coming down with pneumonia," and requests hospital admission. His exam and x-ray were negative. When you ask about the local shelter he states, "They don't want me back there, and the place has no beds anyway."

Reply:

An ED clinician may feel uneasy at the prospect of managing a patient who visits the emergency department frequently, complaining of serious symptoms (e.g., a possible heart attack) but who is homeless and may simply be seeking shelter. What ethical responsibilities are in question?

The situation is common. Emergency department clinicians are obliged to confront a remarkably depressing fact of American life, namely, the existence each night of approximately 700,000 Americans who have no place to sleep, whose indignities are legion, and whose needs may not fit the typical definition of medical care. Homeless persons are more likely than others to use ED services, in part due to lack of access to other regular sources of outpatient medical care or nonmedical subsistence needs.

Emergency homeless shelters are often better at meeting such needs than are EDs, though this is not always the case, and the patient's protestation that the shelters are full is often true. A 2007 assessment in Los Angeles County found that there were 16 homeless persons for every emergency shelter bed.

It's encouraging to note that individuals who access federal Health Care for the Homeless programs are less likely to make inappropriate use of the ED, but such programs are few in number and typically unable to serve all the homeless in any community. Additionally, many individuals, including those with personality disorders or psychotic mental illness, are simply unable to manage the social challenges of a crowded urban shelter. After one or two negative encounters, they may not be permitted to return.

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An ethical path to good care

Admission to the hospital for purposes of addressing a short-term shelter problem, as requested by the patient in our case, violates the norms of hospital use and could impede the hospital's financial viability or its capacity to accommodate the acute medical, surgical and psychiatric cases that require more immediate care. Recognizing this norm, however, is not the same as identifying an ethical path to good care. That requires a return to fundamentals.

First, as with any patient, where medical evaluation produces no signs of acute medical-surgical illness, careful reassurance and education of the patient should follow. Some patients walk away happily once they have clear advice on how to manage a comparatively minor problem. Medical and nursing staff may tend to abbreviate their communications with patients who make them feel uncomfortable, and that tendency simply must be overcome.

Where careful education fails to reassure, however, questions must follow. "I'm puzzled that you are still concerned and think you need admission. Can you tell me what's going on?"

The problem most in need of treatment may not be the one the patient reported and could be anxiety, depression, or withdrawal from alcohol or drugs. It's appropriate to inquire about these conditions in a nonjudgmental fashion.

Are you having a lot of stress these days? Does that include hearing voices? Is alcohol, or coming off alcohol, a challenge right now? Clinicians must diagnose and either refer or treat these conditions, even in an emergency department.

If subsistence needs such as safety, shelter or food appear to represent the primary concern, the encounter will be more productive if the patient is permitted to voice that concern without fear of adverse judgment. Even for patients who are not known to be homeless, I ask, "Can you tell me where you are staying these days? Do you have a safe place to stay tonight?"

To ask this question advances the twin goals of clarifying why the patient has presented for care and reaffirming the dignity of the patient, even if she must acknowledge a challenge that is routinely subject to stigma and shame.

For patients who report having no place to go, there are medical consequences that may result from precipitous ED discharge in the middle of the night. Premature mortality is characteristic of homelessness, and death among people who sleep outdoors often occurs shortly after leaving the hospital. In one study, nine of 13 homeless persons who died outdoors in winter had been admitted to hospitals or treated at EDs within three weeks of death.

Accordingly, while admitting an otherwise-well homeless patient to the hospital is not warranted on medical grounds, clinicians retain a special responsibility to identify the most humane response available. Hospitals must maintain social work or similar staff who know the available resources. Physicians and nurses should be prepared to make a telephone request on behalf of a patient, since their professional status often opens doors (and identifies beds) that the patient cannot access on his or her own.
Balancing humane care and policy

Discharging a vulnerable homeless person into the night, particularly a cold night, properly strikes most clinicians as medically risky. If no medical condition exists to justify admission, then admitting that patient to a hospital bed appears imprudent as a matter of policy. The de facto response in many hospitals is to let the homeless person who has braved five to 10 hours of workup stay on the ED gurney until morning, when warmer weather and open buildings become available. However crude and imperfect this may seem, splitting the difference between short-term response and long-term policy honors the conflicting imperatives of the moment.

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Equally important, however, is for clinicians to inform health system leaders about the impact homelessness has on hospitals and to encourage the expansion of more appropriate and humane options for their patients. In more than 35 communities across the country, medical recovery programs, or respite programs, receive homeless persons who are too ill to recover on the streets and too well for a hospital admission. Two observational studies have shown that respite programs are associated with reduced likelihood of hospital readmission. Many hospitals, health authorities, philanthropic organizations and government bodies remain unaware of the robust data to support this service model.

Homelessness clearly demands a policy response that includes housing interventions and funding for medical respite programs. In the course of an emergency department visit, the fundamentals of good care are the same whether the patient is homeless or not. "The secret of the care of the patient," Francis Weld Peabody wrote, "is in caring for the patient."

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