

Street Medicine: An Example of Reality-based Health Care

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Street Medicine, an emerging field of medicine in the United States, is the provision of health care directly to those living on the streets of our communities. As such, it represents a trend in both health care delivery and medical education in which the reality of those we serve is central. While initiatives such as patient centered care, the medical home and motivational interviewing strive to build health care around the individual, Street Medicine is a more radical attempt to create a care relationship on the terms of those who have been largely excluded from our system of organized health care.

The unsheltered homeless living under our bridges, in our alleys, and along our rivers have arguably the worst medical care in the U.S. in terms of continuity and effectiveness. Many receive care in Emergency Departments or not at all. The life expectancy of a homeless person is approximately 47 years.¹ For those who do not generally use shelters, it is even shorter. In addition, there is growing evidence that the chronic street homeless population incurs a disproportionate amount of cost due to frequent and prolonged hospitalizations and emergency room visits.² If ever there was a case of a system not fitting a population, the chronic street homeless are that case.

The American health care delivery system has become a victim of its' own success. While the system's scope and efficiency are impressive, this has come at the cost of flexibility. Patients are forced to come to the structure of health care delivery and mold themselves to the needs of that system. Indeed, many people never make it into our health care institutions at all, despite having very real needs. Barriers of culture, economics, and other circumstances create gaps between a growing number of citizens and the health care industry. The result is a divorce between established medicine and reality. Our rigid structure prevents us from reaching people. The antithesis would be the traditional house call, in which the physician literally came to the patient in their own world, on their terms.

Dismissed as a quaint historical legacy, the house call deserves a serious second look. By going directly to the patient, the nurse or physician immediately establishes the centrality of that person's reality. This creates trust, and an acknowledgement that any health care plan will be grounded in a shared recognition of real circumstances. The person is honored for who they are. Even if this occurs only one time, the patient will forever value the respect they were given and are more likely to work in partnership with us. Equally important is the insight we gain about the actual determinants of the patient's health. We see the forces at work in their lives and health. Without such information we are working with incomplete data. This is illogical if our goal is truly

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to achieve good outcomes. As the great William Osler* is said to have advised, “Ask not what disease the person has, rather what person the disease has.”

Without such insight about the person behind the disease, health care practitioners are working in the dark. We continue to apply paradigms to symptoms that persist, or worsen, because we do not understand their source. When considered from a distance, such a lack of understanding begins to resemble a collective thought disorder, as health is de-contextualized. Domestic violence is a classic example in which abused people are “treated” over and over for depression, non-compliance, worsening medical conditions, and various injuries. Despite two decades of medical education on this issue, most health care systems do not adequately recognize the health consequences of domestic violence. There is a tragic reality gap between the world of health care and the world of the domestic violence victim.

Can we learn how to learn more? Is there a classroom in which we might be given the opportunity to set aside our own contexts and fully understand the reality of those who have been excluded? Are the skills of crossing the reality gap ones that we can identify and include in our health care educational system?

I believe it is time that we define and develop the concept of reality-based health care. Regardless of the patient or population group, we must learn the skills that will allow us to meet patients where they are and understand the forces that challenge and support their well-being. We can practice health care with many and varied motivations. These include incentives for re-imburement, fear of liability, and our own preferences and prejudices. If we are to be relevant to those we serve, we must begin—soon—to work with the reality in which they live and die. We need to explore the reality of those for whom the system is not working. The street homeless happen to be excellent teachers in this particular arena.

In 1992, I began to dress as a homeless person and go out at night with a formerly homeless man to make “house calls” to the people sleeping on the streets of Pittsburgh. My intention was to strip away my medical-control structure and find a way to become a part of the street world. From my work as a faculty member in the Department of Internal Medicine at The Mercy Hospital of Pittsburgh, I was well aware that street people were frequenting our hospital, yet despite our best efforts, their care was usually ineffective. As a medical educator, I wanted to find a classroom on the streets that would force us to work on their terms. In any other setting, those who were able to access our system would always be bending to our structure. I was seeking those who were not able to come to us. I would need to go to them. It soon became a very personal experience.

One of the first “street professors” I met was known as Grandpa. He was, incredibly, 82 years old and living a nomadic life on the streets of Pittsburgh. It was a strange first encounter, as I was dressed in my homeless style and he was leaning against a building amongst his bags of belongings. His right leg was extended and swollen. As fluids were obviously seeping through his pants legs, I could tell something was terribly wrong.

* William Osler, a Canadian physician, was one of the four professors who founded Johns Hopkins Hospital. He lived from July 12, 1849–December 29, 1919.

I cautiously sat down next to him, and the smell confirmed my suspicions. His eyes twinkled in a charming smile as I introduced myself.

“They call me Grandpa,” he said, as he extended a calloused hand.

“My name is Jim. I’m a doctor.”

Grandpa looked at me skeptically. “What kind of doctor are you?”

“I work at Mercy Hospital and I teach Internal Medicine.”

“That’s a good field. What are you doing out here?”

“Well . . . I guess I wanted to learn about the folks who are out here. I want to see what kind of medical problems they have and if I might be able to help.”

I looked at his leg and offered, “It looks like you have a problem with your leg?”

“Ah! That’s the MASER beams. They follow me wherever I go and shoot me with them. Do you know about MASER beams? They’re like LASER beams, but they’re made out of *microwaves*. . . .”

Thus began my first lesson in Street Medicine. Grandpa was a unique and wonderful soul, but typical of many of our dear, older homeless people. His paranoid thoughts led him to a life on the run, never resting, always moving and hiding from those he believed were pursuing him. Gravity and age conspired to swell his legs and, inevitably, he developed hideous ulcers. The legal and medical systems had decided he was competent to manage his affairs (we tried to commit him numerous times, but were over ruled). In the end, he was exactly where he was, suffering exactly as he was, due to who he was and who we were—as a system. This was a very wonderful, very sick man without any health care.

In subsequent months, I tracked Grandpa through a growing network of agencies, bus drivers, and hunting expeditions. I cleaned his leg as best I could in alleys and bus stops. No matter how hard I tried, he would not seek care at a proper medical facility. I was learning to bend my world to his. Even when logical argument failed, I discovered that my dedication earned me his trust. He taught me that I was not in control of his world, but he slowly began to welcome me deeper and deeper into his reality. I gained enormous respect for his courage and strength in the face of a very difficult life. No matter how bad things were, he would give me his gifts of encouragement and love. I felt I wasn’t accomplishing much, but at least we had made our connection.

One morning, I entered the teaching clinic through the side door and the nurse stopped me.

“There’s an old man sleeping in the doorway. He said he’s waiting for you.”

Quickly I made my way to the front door and Grandpa sat up to look at me. I realized he had never seen me in my tie and lab coat.

“You **are** a doctor!” he said, “You really **are** a doctor!”

I had to laugh as I escorted him back for his first medical visit to the clinic. But as I did so, I came to a deeper realization. In a real sense Grandpa was telling me something about himself and our relationship. For the first time, **he could have a doctor**. He could be who he was (which he could not change) and have access to a physician. We had found a way to bring health care close enough to his reality that health care was possible *for him*.

One homeless person at a time, we built our relationship with the street community. In the following months and years, many dedicated volunteers and staff joined our

work. Now teams of medical and formerly homeless walk throughout our community and a medical van provides care for those who prefer to come there. The resulting program is known as Operation Safety Net. Not only do we provide direct care to our clients at night, but we have established the first 24-hour “home care” service for the street homeless of our city. Emergency rooms can call at any hour and we are able to advise them on the care of the street homeless. With our web based database, we are always able to stay updated on the details of each person and can follow up, if need be, under their particular bridge. Our specialized street homeless consult service allows the hospital to provide care and discharge plans that are reality based. It is also an excellent learning opportunity for our students and humanizes each homeless patient. At our office, clients are seen and provided social service counseling, legal assistance, insurance navigation, and a wide range of supportive services. Over 400 street people have been housed through our program in the past four years. We have over 100 health-care-related students that work with us each year.

In time, the field we call Street Medicine has become a movement. More and more pioneers of this work have been identified and linked. A growing number of communities have reached out to learn about, and create Street Medicine programs for themselves. With the support of Glaxo SmithKline and the Robert Wood Johnson Foundation, we held the first International Street Medicine Symposium in Pittsburgh in 2005. The 6th such meeting was held recently in Los Angeles with participants from Europe, Asia, North and South America. One of the most encouraging facets of this global collaboration for me is the involvement of medical, pharmacy, nursing and other students. It is our vision that one day, every community will have a Street Medicine program and every health school will have access to our “classroom of the streets.”

Our most recent milestone is the establishment of the Street Medicine Institute, which will serve as a consulting entity for interested communities, serve as a central resource to develop and improve the practice of Street Medicine, host the annual meetings, and create educational opportunities for future health care leaders (www.streetmedicine.org).

As I look back on this journey, I find it critical to remind myself and others that although the work of Street Medicine serves the homeless, is also vital for the wholeness of the larger community. Street work has always been a mirror through which we may see ourselves. It is a testing ground for whether we are inclusive or exclusive as a society. And for the health care community, it is a challenge. Can we work with people in their reality, as well as ours?

Notes

1. Hwang SW, Orav EJ, O’Connell JJ, et al. Causes of death in homeless adults in Boston. *Ann Intern Med.* 1997 Apr 15;126(8):625–8.
2. Culhane DP. The costs of homeless—a perspective from the U.S. *European Journal of Homelessness.* 2008 Dec;2:97–114.