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Ethical and Legal Questions with Street Medicine

Gordon Wong

ABSTRACT
The homeless problem has been worsening in the U.S. for many years. Homeless residents have many health issues. Yet their healthcare needs are difficult to be met. To address this problem, the federal government and state governments are encouraging the implementation of Street Medicine programs by providing funding and changing regulations. However, due to the unique characteristics of this population, there are many ethical and legal issues related to delivering care to them. These issues have not been well discussed. This paper attempts to highlight the ethical and legal issues in Street Medicine. The goal is to call the attention of all the stakeholders to these issues so that meaningful discussions can begin.

Keywords: Street Medicine; Homeless Patients; Medical Ethics; Medical-Legal

INTRODUCTION

This paper identifies and discusses ethical and legal issues related to the implementation of Street Medicine programs. "Street Medicine is the practice of providing medical care to unsheltered people experiencing homelessness in locations like encampments, parks, and under bridges" (National Health Care for the Homeless Council, 2020). It is currently receiving much attention from healthcare policymakers; health plans; and provider organizations. However, its development is relatively new, and the related ethical and legal issues have not been fully discussed. Some of the ethical and legal issues are at the individual clinician level, some are at the organizational level, and some affect both. Some issues are unique to the Street Medicine environment. Others are present but rare in regular healthcare settings, but common in Street Medicine. Understanding these issues is necessary for developing and implementing effective initiatives.

Because empirical data on Street Medicine programs are not widely available, there are no definite answers or solutions to many of these issues. The goal of this paper is to raise questions to start public discussions on them as the first step in developing more effective programs.

BACKGROUND

Homelessness has become an epidemic in the U.S. The federal government estimated that currently over 500,000 are homeless. Most of them are concentrated in the Pacific Coast states; New England; New York; and Hawaii (National Alliance to End Homelessness, 2023). It is no surprise that homeless people have much worse health conditions when compared to the general population. A recent report found that 21% of them have mental health problems and 16% have substance abuse (Saldua, 2024). A majority of them are ethnic minorities (37% African American, 24% Hispanic). Another report estimated that the prevalence of chronic diseases such as diabetes, heart disease, and HIV, among the homeless are 3-6 times higher than the general population (National Alliance to End Homelessness, 2023). About 25% of the homeless have a criminal record (Metraux & Culhane, 2006). Over half of them have experienced violence as a victim (Meinbresse et al., 2014).

Despite their poor health conditions, the homeless are not receiving adequate care from the current healthcare delivery system. All levels of government are trying to address this issue. The federal government revealed its plan to reduce homelessness by 25% by 2025 (United States Interagency Council on Homelessness, 2022). The American Rescue Plan Act of 2021 provides funding to house and to provide medical care for the homeless (U.S. Dept. of Housing and Urban Development, 2021; California Health Care Foundation, 2022). One regulatory change that has been called a “game changer” is the Centers for

Medicare and Medicaid Services (CMS) allowing public and private insurers to pay "Street Medicine" providers for medical services delivered at any place homeless people might be staying (Hart, 2023).

Equipped with funding and the new regulation, states are rushing to develop programs to serve this population. For example, the California Department of Health Care Services (DHCS) is requesting all Medi-Cal health plans to submit proposals for a "Street Medicine" initiative (California Dept. of Health Care Services, 2024).

Implementing special programs to care for the homeless is a laudable mission. However, this patient population is very different from the general public. There are many challenges when providing services to them. This paper will discuss the ethical and legal challenges.

Delivering Care Using the Harm-Reduction Model

Providing care to the homeless is very different than providing care in other settings. Due to the transient nature of the patients; many have problems with compliance to treatments. It is difficult to provide them with the same level of care available to other patients.

Policymakers are aware of these limitations. For example, the California DHCS has explicitly stated that "Street Medicine to be a harm reduction tool". The Harm-Reduction model has been a cornerstone in many public health interventions such as drug use; sexually transmitted diseases (STD) prevention etc. (Hawk et al., 2017). In Street Medicine, this means that less-than-ideal treatment outcomes may be acceptable.

The Harm-Reduction model has merit in addressing problems such as needle sharing and STD transmission. When applied to chronic disease care in Street Medicine, it creates very different ethical and legal dilemmas. This is due to the high rate of non-compliance and loss-to-follow-up.

Medical Considerations

The first ethical duty of a physician is "Primum non nocere (Do no harm)". While any treatment has some potential risks and side effects, the potential benefit of treatment offered to any patient must outweigh the potential risks.

In Street Medicine, when treating acute illnesses, this is usually not a major concern. The benefits of treating an injury or acute infection such as pneumonia usually far outweigh the risks. However, for many chronic conditions, when the chance of non-compliance or loss-to-follow-up is high, the risk-benefit analysis will yield different results.

Infectious diseases that require long-term treatment are the most affected conditions. HIV; tuberculosis; and hepatitis B and C are common among the homeless. They require an extended period of treatment with antimicrobials. Incomplete treatment will lead to the growth of drug-resistant organisms. This puts both the patient and the public at a greater risk. The dangers of drug-resistant bacteria and viruses to public health are obvious. For the patient, incomplete treatment will lead to the presence of drug-resistant microbes in his/her body, making it much more difficult to treat in the future, when clinical symptoms appear or worsen.

For non-infectious chronic diseases, incomplete treatment may pose less risk to the public but still shift the risk-benefit analysis for the patient. One goal of treating a chronic disease is to prevent adverse events from happening in the future. For example, when treating diabetes, the main goal is to prevent the development of complications such as myocadiac infraction; renal failure; blindness, etc. A patient must continue with treatment to get the benefit. However, risks of treatment such as hypoglycemic events; lactic acidosis (from metformin); and acute renal injury (from SGLT-2 inhibitors) tend to occur early in the course of treatment. Difficult to follow-up homeless patients are at a higher risk for these adverse events and are much less likely to benefit from the treatment because they won't or can't stay on the medication for many years.

Ethical Considerations

The above clinical issues are creating special ethical and legal challenges to Street Medicine, especially when treating chronic diseases. If the treatment outcome is 100% certain, "primum non nocere" is straightforward. In the real world, whether a treatment will generate the desired outcome or cause an adverse event is only known after the treatment has been rendered. Clinicians and patients must make decisions based on probabilities.

Consider an ordinary patient with stage 4 cancer requesting aggressive treatments with surgery and chemotherapy that have only a 10% chance of success, but will likely cause severe side effects. As long as the patient is mentally competent, and the healthcare resources to be used are not outwardly disproportional to other care, under the principle of "patient autonomy", it is not unethical for a physician to render such treatments to the patient.

The consideration is different for a homeless patient diagnosed with latent tuberculosis. The patient currently has no symptoms and is not contagious. But this can change over time. Should long-term treatment be offered to this patient? The patient has a high chance of not completing the course of treatment, resulting in the development of multi-drug-resistant bacteria, harming the patient and the general public. However, it cannot be 100% certain that the patient won't finish the treatment. Should the clinician offer the patient the options and let the patient decide, knowing that incomplete treatment will harm the patient and the public? Or should the clinician not offer the treatment at all? If the patient specifically asks for treatment but the clinician feels that it is highly likely that the patient will not complete the course of treatment, should the clinician refuse to treat? These are all ethical issues a clinician must address.

Legal Considerations

In addition to the above ethical dilemma, a clinician decided not to offer long-term treatment to a homeless patient due to the concern of potential risks may face legal consequences. In a regular healthcare setting, the clinician has a duty to inform the patient of all treatment options and let the patient decide which one to take. The clinician should warn the patient about the risks associated with non-compliance, but should not assume that the patient will not comply with the course of treatment. Since the clinician will maintain regular contact with the patient, the treatment plan can be adjusted. However, in Street Medicine, the likelihood of not completing the treatment cannot be ignored, and clinicians may not be able to assess for adverse events or adjust the treatment plan.

Concern for Malpractice

When knowing the fact that failure to comply with a long-term treatment regimen is likely, should the clinician not even present this option to the patient? If the patient requests to be treated, should treatment be rendered? When the clinician fails to offer treatment for the latent tuberculosis of a normal patient, and he later develops active disease, the clinician would likely be found to have committed malpractice. But what if the clinician does not treat a homeless patient due to concern about the elevated risks, has he breached his duty to the patient and is liable for malpractice?

On the other hand, if a clinician renders treatment to a patient, but the patient suffers an adverse result due to non-compliance, the clinician may still be sued for malpractice (Grippe v. Momtazee, 1986). If the clinician had provided ample warning to the patient about the importance of compliance, and had the discussion documented, that could be a valid defense based on contributory negligence. However, in reality, likely, many clinicians will not have enough time to adequately document the discussion. It is also much easier to lose contact with a homeless patient after a few encounters, hence being unable to do longitudinal patient monitoring to assess for compliance and adverse effects. Could new standards or processes be required to address the problem of non-compliance?

Standard of Care and Potential Discrimination Challenge
Legally, a clinician's duty is based on the standard of care – "what a reasonable clinician will do in the same situation". If different standards of care exist for treating homeless patients with certain diseases, the clinician can use this as a defense for not offering a treatment. Ideally, care standards are developed by professional organizations based on evidence. Health plans and provider organizations then will adopt these standards as their own and request their clinicians to follow them, although clinicians will have some flexibility to deviate from a standard based on their clinical judgments.

Because Street Medicine is new, few data are available for developing treatment standards for this population. Furthermore, there may be legal challenges to the development and adaptation of different care standards.

Over half of the homeless population are ethnic minorities. If different standards of care are used for this population, could it be challenged as a de facto racial segregation (Balsbaugh et al. v. Rowland, 1972)? Street Medicine is primarily funded by Medicaid programs in each state. Since it is a government program, its policies on race are subjected to the Strict Scrutiny standard. Adopting different care standards for Street Medicine can theoretically lead to a constitutional challenge.

PATIENT ABANDONMENT

Once a physician-patient relationship is established, it is unethical; a medical board punishable unprofessional conduct (e.g., in California, this is stated in the Business and Professions Code - BPC § 4955(k)), and breach of duty for the physician to abandon a patient during treatment. To discharge a patient, the physician has to notify the patient in writing and give the patient a reasonable opportunity to obtain service from another physician.

In Street Medicine, patients do not have a permanent address and may not be found easily. When the treating physician has to terminate the physician-patient relationship, such as in the event of changing jobs or changing health plan contracts, it may not be feasible to comply with the medical board's required process to notify the patient. The physician can be punished by the medical board for patient abandonment, and be liable to patients for malpractice.

PRIVACY CONCERNS

Privacy is a critical element in healthcare. Patients must have full confidence that their medical information will be protected. Otherwise, it will be difficult to establish rapport between a patient and clinician. There are several specific privacy issues associated with Street Medicine.

Privacy Related to Accessing Care

The most obvious problem is with providing care in a public area. For non-emergency services, mobile medical vans or tents may be used for patient encounters and to maintain privacy. However, a patient seen going into an encounter is already a privacy concern (Bernstein, 2014). Homeless patients live in very close proximity to others. Being seen receiving medical care may be detrimental to their status among their peers.

HIPAA Issue

Privacy in healthcare is mainly governed by the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rules (45 CFR Part 164 Subpart E). Health plans and healthcare providers that submit claims electronically are covered by HIPAA (Covered Entities). If a covered entity engages a business associate to help carry out its healthcare activities and functions, the covered entity must have a written Business Associate Agreement (BAA) that requires the business associate or subcontractor to comply with HIPAA.

The coordination of services between clinicians and other agencies is an integral part of a Street Medicine program. The program is designed to assist patients in housing; job development; welfare applications, etc. Sharing of information among agencies is needed.

At this time, many of these agencies are not HIPAA-covered entities because they work independently outside the healthcare system. For ordinary patients, clinicians routinely share information with non-clinical organizations upon requests by patients. For example, per patient request, a physician will clear a patient to participate in a job training program and send medical records to a job training agency. In this scenario, no BAA is required because the sending of medical information is controlled by the patient.

When working with Street Medicine patients, the process of sharing information may be different and more complex. Consider this hypothetical example: a Street Medicine program coordinates services with a housing agency and a job training agency, both need to know some medical background about a patient. The Street Medicine program can obtain patient consent before sending information to the housing and job training programs. Since the housing and job training programs are not HIPAA-covered entities, they are regulated by different privacy rules. Most states have privacy laws regulating government agencies, private organizations, and non-profit organizations on the disclosure of personal information. However, there may not be a universal standard across all organizations. For some organizations not receiving government funding (e.g. faith-based organizations offering job interview training), client privacy may only be protected by general tort laws.

Non-government organizations receiving government funding may be required to submit data to the funding agency. Once data is under the government's control, it is subject to the federal Freedom of Information Act (FOIA) and/or each state's similar statute. The handling of personal health information varies from jurisdiction to jurisdiction. The federal FOIA permits federal agencies to withhold "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." (5 U.S.C. 552(b)(6)). However, execution of this exemption is on a case-by-case basis at the discretion of the agency. Some states' open records laws even trump HIPAA (Cameron, 2008).

With such a complex system, patients no longer can be certain that their health information is adequately being protected. Strictly speaking, this is not an issue unique to Street Medicine. But if Street Medicine programs become successful, the volume of medical information shared will proliferate. Will this significantly increase the administrative burden for the non-healthcare agencies? Are homeless patients having a significantly higher risk of having their privacy violated? Should non-healthcare agencies become HIPAA-covered entities or require a BAA? Will small agencies even refuse to work with Street Medicine because of concern about the administrative burden? Only time will tell.

Physician-Patient Privilege

Unless explicitly required by law, physician-patient communications are a legally protected privilege and cannot be admitted to court without the consent of the patient. When medical information is sent to other organizations, it may no longer be privileged.

Similar to the above discussion on HIPAA and privacy, this is not a unique issue for Street Medicine. However, the potentially large amount of information sharing required to coordinate services, and the high prevalence of legal issues among this population, will make this a much more prominent issue.

For clinicians, knowing that the medical records for Street Medicine patients have a much higher chance of not being protected by privilege, creates a potential ethical and professional dilemma: should the clinician document differently to minimize the impact that the medical records may be used detrimentally against the patient?

For Street Medicine patients, if they correctly or erroneously believe that their communication with clinicians may later be used against them in court, or be used in other legal proceedings involving

situations that a patient victim does not want to reveal his/her identity (e.g. in human trafficking or sexual assault cases), will they be willing to honestly share information with the clinicians? Can the Street Medicine program legally and ethically develop some policies or processes to alleviate these concerns?

STREET MEDICINE AND OTHER SOCIAL SERVICES

Street Medicine programs offer a much boarder type of services. The most important one is housing. At least 19 states are using Medicaid funding to provide for temporary housing and several more are applying to do so (Hart, 2024). Employment, education, food security, social and community context, and transportation are also receiving funding from health systems. It is estimated that between 2017 and 2019, $2.5 billion was spent on these services, with $1.6 billion going to housing. The "mission creeping" of healthcare into social services is more than just at the funding level. Healthcare providers are directly providing non-medical services to Street Medicine patients (Horwitz et al., 2020).

Researchers have questioned the healthcare organizations getting involved in other social services. This is "diverting scarce resources to socially less-desirable uses, with few prospects of success" (Glied & D'Aunno, 2023). Even supporters of using Medicaid funding for housing admit that there may be no financial return on this investment, and no reduction in the use of medical services (Hart, 2024).

Even when ignoring the issue of different stakeholders competing for limited financial resources, healthcare providers offering social services have another ethical issue: Are healthcare organizations qualified and equipped to work as social services providers? If a healthcare organization has to provide temporary housing, and if the volume is high enough, the organization could become a real estate developer and property manager (similar to a staff model HMO owning labs, radiology services, and skilled nursing facilities). But should healthcare organizations enter into such services? Will this erode the organization's core mission to provide care?

FIDUCIARY DUTY TO PATIENTS VS. OTHERS

In most circumstances, a physician has an ethical duty to place the patient's interest above all others (American Medical Association Code of Ethics 10.015). This fiduciary duty should only be breached when a third party is in imminent danger of being harmed by the patient (Tarasoff v. Regents, 1976). However, in Street Medicine, the potential for clinicians to encounter a conflict-of-interest scenario has significantly increased.

Street Medicine encourages organizations to offer social services beyond traditional healthcare. A conflict of interest can occur when the organization owes a fiduciary duty to multiple clients with competing interests. For example, if a patient requires temporary housing run by the healthcare-providing organization, but the organization knows that accepting this patient will be detrimental to the well-being of other existing residents (e.g. requiring a disproportional amount of resources). Whose interest should the organization consider first? Ethically this is different from just trying to place the patient in an unrelated facility, in which the ethical duty of the clinician is to forcefully advocate for the patient.

Another ethical dilemma arises when there is a question of whether a third party is in imminent danger. Street Medicine patients have a much higher prevalence of mental disease; low socioeconomic status; and personality issues. Therefore, it is natural that they frequently will express statements that would be considered offensive or threatening by ordinary people. Clinicians in a normal setting may rarely encounter this situation, but Street Medicine clinicians may hear such statements regularly.

When will a patient's hostile comment towards others triggers the duty to warn? Street Medical mental health clinicians must make a decision each time they hear a hostile statement directed towards an identifiable individual. If the clinician fails to report a threat resulting in injury to a third party, the clinician is legally liable. But if the clinician reports a statement that the patient only made out of

frustration and habit, then he/she is causing harm to the patient. This will also destroy any rapport the clinician has developed with the patient.

Although the same situation will occur during any clinical encounter, the chance that this may happen in Street Medicine is much higher. This puts mental health clinicians in a "damned if you do, damned if you don't" dilemma.

CONCLUSION

Ideally, the U.S. homeless problem will soon improve. However, the problem likely will never completely disappear. Street Medicine programs are one component of the solution.

But Street Medicine has many features different from regular healthcare services. There are ethical and legal challenges either unique to or amplified by the Street Medicine environment. Unless these issues are openly discussed and addressed, Street Medicine clinicians will routinely encounter ethical and legal dilemmas that affect how they deliver care.

This paper raises many unanswered questions and brings the critical ethical and legal issues to our attention. It is hoped that we can start meaningful discussions and come up with solutions acceptable to all parties. Ultimately, new clinical guidelines and new legislation may be required to make Street Medicine work.

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