The moral urgency of street medicine





HELEN H. GLASER STUDENT ESSAY AWARD WINNER

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> "I cherish the day, I won't go astray, I won't be afraid / You won't catch me running."[1]
>
> —Sade

I first met John in the brisk Chicago air that portends winter, leaning on the glass outside a McDonald's, on one of my first street medicine runs as a freshly minted first-year medical student. His eyes surveyed a scene he'd seen a thousand times: some helpful group coming out to the encampment to hand out services and supplies. He seemed pleased to see us, yet guarded; his first question was whether our sandwiches that week had turkey. When we asked him how he was doing,

he endorsed crushing chest and abdominal pain, then declined further questions from the attending and wandered off, clearly in pain.

This became a cycle. We would go out to the encampment, John would endorse some alarming set of symptoms, and then deny further care before disappearing into the alley behind McDonald's.

Over the next six months, I developed a rapport with John until one day I felt emboldened enough to highlight this cycle and almost pleaded with him that we were there to help. His usually incisive eyes glazed over, looking at me, but really looking through me into his memories. He muttered: "I've been on these streets for 15 years. I've been drinking since I was 13 years old. No one has ever given a f**k about me. The damage is done."

At that moment, I realized John had refused care not because he wasn't concerned about his symptoms, but because he didn't think he was worthy of care. Years of being unhoused had taught him that he shouldn't expect care, or even dignity. Frankly, he was right: he had been chronically unhoused, with overlapping substance use disorders, for decades, and society had never shown him a modicum of care.

"John," I whispered into the bitter Chicago winter, "We're here. We care. I care."

The next time we were out, John, predictable as ever, was leaning on the glass window of McDonald's.

"My chest hurts. I need to speak to her." His finger stabbed over my shoulder at the attending physician.

The health effects of being unhoused are as severe as they are well-characterized. Houselessness, particularly unsheltered houselessness, exposes a person to extreme weather, constant stress, violence, and unsanitary conditions. This burden shows up in the high prevalence of chronic illnesses such as heart disease, diabetes, and HIV. Moreover, nearly two-thirds of unhoused individuals report serious mental health conditions, such as schizophrenia or depression, alongside concomitant substance use disorders. Taken together, unhoused patients face a mortality rate nearly four times higher than their housed counterparts and on average die decades earlier.[2–4]

Despite this outsized disease burden, unhoused individuals face extreme barriers to care: no reliable phone or mailing address (making insurance and follow-up challenging, if not impossible), limited transportation, and often no identification. In the survivalist ecosystem of the unhoused, medical appointments become a low priority until they become a crisis. In practice, treatable conditions go unaddressed until they escalate into life-threatening emergencies. Only then do patients seek crisis care in the emergency department where they are stabilized, discharged, and the cycle repeats. Even when unhoused individuals do seek crisis care, they face discrimination and stigma, making them less likely to seek future care. In our own street medicine practice, patients tell us stories of dehumanizing experiences in the ER, and when our team recommends transport, they accept it less than five percent of the time.

This leads to clear downstream harms. There is rarely meaningful continuity of care when an unhoused patient cycles through emergency rooms, resulting in short-term fixes and impersonal encounters. This not only further disenfranchises patients from the healthcare system, but also places significant economic burdens on that same system. The average unhoused person visits the emergency room five times per year, costing taxpayers over $18,000 annually, while a chronically unhoused individual with frequent crises can incur more than $44,000 per year in emergency department costs.[5] In short, we pay the cost of treating people once it's too late in both dollars and lives.

These realities are not just stories of individual hardship, but failures in our social and medical safety nets. As noted by academics and journalists, houselessness is a political and social choice.[6] However, it is not a choice made by unhoused individuals, but rather one made by a society that places unhoused individuals into a social underclass. We see those choices in recent budget requests that slash over $500 million for homelessness services, and in legal decisions that move toward criminalizing unsheltered houselessness, including the Supreme Court's ruling in Grant's Pass v. Johnson.[7,8] As Illinois Chief Homelessness Officer Christine Haley put it: "Homelessness is the product of generations of inequitable public policies."[9] In other words, society's most marginalized have been made especially vulnerable to ill health by our policies and neglect. As these trends continue, and broader structural change remains slow, individual choices become more important.

Street medicine intervenes where conventional systems fall short. It's a simple yet radical idea: instead of waiting for patients to come to the clinic, street medicine brings the clinic to patients, providing care under bridges, in alleys, and in encampments. This model was pioneered in the 1980s by programs like Boston Health

Care for the Homeless (BHCHP). At BHCHP, Dr. Jim O'Connell and colleagues began delivering care on park benches and street corners when they realized many chronically homeless people would not or could not come into hospitals. Over the decades, what started as a one-man effort with a tackle box of medical supplies grew into a multidisciplinary street team in Boston. The BHCHP street team now includes clinicians from multiple disciplines—doctors, nurses, psychiatrists, and social workers—who conduct street rounds most days and even accompany an overnight outreach van on some nights. They dress wounds under bridges, vaccinate people in parks, and perform portable ultrasound exams in alleyways, continuing the lifesaving work that Dr. O'Connell began in 1985.[10,11]

The effect of this approach is not only immediate, such as treating an infection, but also deeply relational. Rather than a hurried clinic visit with a stranger, street medicine offers time and presence. Teams return to the same spots regularly, building trust over weeks and months. Patients who once distrusted the healthcare system begin to accept treatment, and even seek it out, because it comes from familiar faces who have proven that they care. In Boston, BHCHP reports that many long-term patients have eventually transitioned into housing through the trust and support built on the street. It is the trust, more than anything, that often proves lifesaving. As BHCHP itself notes, the compassionate relationships formed by the street team eliminate "the barrier that mistrust and judgment from the health care system so often places in between rough sleepers and wellbeing." [12]

Crucially, street medicine also serves as a bridge to broader healthcare systems and social services. While it is heartening to see John begin to accept care, the ultimate goal is not to keep treating John on the street forever, but to help John obtain stable housing. Street medicine acknowledges that healthcare and housing are inseparable: you can't manage someone's diabetes or heart failure effectively if they're sleeping on concrete or in their car. Thus, the mission is twofold: provide the best care we can right now, and advocate to get our patients into safer, more stable situations.

While some institutions, such as BHCHP, are lucky enough to have interdisciplinary teams and broad institutional support, most institutions do not have a funded street medicine team, often being run by volunteer physicians, social workers, and medical students. For all its impact, street medicine is still often treated like an exception: something generous people do after hours, but not something the system should provide. This leaves a stark incongruity between the healthcare needs of unhoused patients and medical institutions' willingness to meet these needs and forces a moral question. Is this work optional charity, or something we are obligated to do?

It should make no moral difference whether a patient is in a clinic exam room or sleeping on the sidewalk. Australian ethicist Peter Singer can help us understand this question further. He begins his famous 1972 paper, *Famine, Affluence, and Morality,* with a simple thought experiment. Imagine you are walking across a bridge, and you see a child drowning. It seems clear to most of us that the morally correct thing to do is to save the child, even though our clothes might get wet. Indeed, we might be called a monster if we admitted we didn't save the child because we didn't want to ruin our clothes. Singer then asks what the difference is between that child and a poor child in Bengal, other than proximity. He writes that it "makes no moral difference whether the person I can help is a neighbor's child or a Bengali ten thousand miles away." Thus, he formulates his moral principle: "If it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, then we ought, morally, to do it." Put simply, we are morally obligated to help those who are "drowning" in society, irrespective of proximity, as long as we are not giving up something more morally important in return.[13]

This sentiment of care is reflected in the ethos of medicine. The AMA Code of Medical Ethics echoes this sentiment, stating that "each physician has an obligation to share in providing care to the indigent," and that all doctors should ensure the needs of the poor in their communities are met as part of their regular practice.[14] The value of their life and our duty to protect it are the same. Extending Singer's account, if a physician can prevent an unhoused person's death "without sacrificing anything of comparable importance" (in other words, by dedicating resources smaller than the value of a human life), then not doing so is ethically indefensible.

Singer confronts us with a demand for action. It is not enough to feel pity, or to consider street medicine a laudable extracurricular. He argues simply that failure to act is morally wrong. In our terms, allowing unhoused patients to languish without care when we have the means to help is akin to walking past the drowning child

because we don't want muddy shoes. This moral framework sets a high bar: it demands proactive outreach, recalibrating street medicine from a compassionate choice to a morally urgent mission.

To be clear, the ultimate solution is expansion of housing, medical systems and social safety nets, and advocacy towards these ends is crucial. However, in lieu of these systemic changes, we all have a role to play in working towards caring for these vulnerable populations.

So, what does this moral urgency demand from us, in practice? For healthcare systems and institutional leaders, this demands economic investment in disadvantaged communities, and concurrent advocacy on behalf of those communities. If you're a physician, this may mean looking up the street medicine organization in your area and volunteering, one evening a quarter, consistently, until you're no longer a stranger. If you're in training, this may mean seeking the expertise of hospital social workers who understand what resources exist and how we can connect patients to those resources.

There may be many understandable reasons clinicians cannot go on a street medicine run. Burnout and resource constraints are realities of the systems we live in and work under. However, Singer still forces the question: what can we do? For some, this might mean distant support through education or donations, and for others it may mean regularly seeing patients on the street. Our options are shaped by our resources, but Singer reminds us that we must do what we can, when we can. The only wrong option to Singer's question is doing nothing at all.

Street medicine asks a fundamental question: what kind of medicine do we want to practice? Street medicine aims to deliver medical care, but it is ultimately defined by dignity. By leaving the familiar confines of clinics and wards and by taking our expertise to the streets, we redefine our relationship with our unhoused neighbors in a way that centers their dignity in ways that medicine too often fails to do. At its core, the ethical practice of medicine demands that we recognize the dignity and shared humanity of all people.

I cannot end this with the kind of heartwarming resolution that would make this an easier story to read; reality is too sharp for that. We still regularly see John on the street, and his stability waxes and wanes. So, I will end with what is true.

John loves Sade (his favorite song is "Cherish the Day"). John has a new grandson, who he has nicknamed "DD." John mourns his father's death every October. John is a fan of the Chicago Bears. And every time I lace up my boots before a run, I pray this isn't the day I find out he's dead; that his spot outside McDonald's is now empty, leaving behind a catalogue of what he loved: Sade, DD, and the Bears.

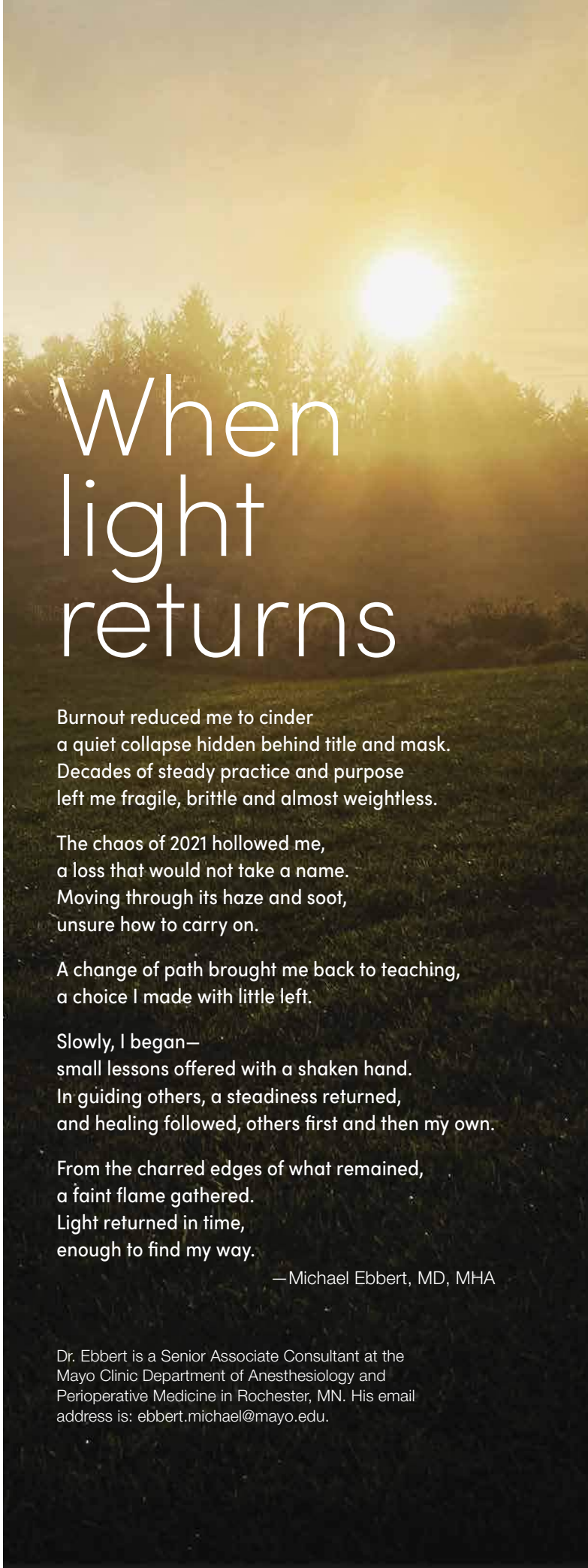
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When light returns

Burnout reduced me to cinder
a quiet collapse hidden behind title and mask.
Decades of steady practice and purpose
left me fragile, brittle and almost weightless.

The chaos of 2021 hollowed me,
a loss that would not take a name.
Moving through its haze and soot,
unsure how to carry on.

A change of path brought me back to teaching,
a choice I made with little left.

Slowly, I began—
small lessons offered with a shaken hand.
In guiding others, a steadiness returned,
and healing followed, others first and then my own.

From the charred edges of what remained,
a faint flame gathered.
Light returned in time,
enough to find my way.

—Michael Ebbert, MD, MHA

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