

# What Homeless people do expect from hospitals: results of an ethics study about patients' autonomy.

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## • Introduction:

As a clinical centre we are very concerned by the ethical reasoning that leads to medical decisions. And especially the place to be accorded to the principle of the respect of autonomy balanced with beneficence, non maleficence and justice.

After some specific causes concerning homeless, poor and/or vulnerable people we were wondering if this balance should be the same or not for this specific population. Indeed, either this population is seen as very vulnerable and in need of a specific protection, or precariousness reduces autonomy. For example are we allowed to send somebody to hospital against his will in order to be sure he observes his treatment because we think that in the street he will not be able to get a good enough observance? Or else, do we have to go towards homeless people who could benefit from psychiatric care though they don't ask for it?

The question is to know how much the social environment has to be taken into account in health care strategy. Or how far should we avoid giving him too much importance in order to provide an equal access to health care? Do we need to think that precariousness calls for another behaviour even if it challenges patients' autonomy? In this context, we can define autonomy as the ability for people to express what they wish for themselves. This first definition does not exclude some broader definitions.

Faced to these questions we thought relevant to focus on homeless patients' expectations when they go to hospital and how much they want the institutions to respect their autonomy. That's why we decide to design a study to provide a better understanding of homeless patients' requirements towards hospitals; the way they express it and the answers proposed by health care institution.

More precisely we chose to compare three settings:

- Setting 1: the emergency room of a general hospital.
- Setting 2: an out-patient setting specialised for underprivileged people
- Setting 3: a "mental health and social exclusion service".

This study should help us rethinking our practices through an ethical reading of the topic.

## • Patients and methods:

The study design was of a qualitative and prospective inquiry through clinical ethics interviews conducted by a physician together with a non physician (mainly social scientist researchers) and conducted in each setting. When arriving to one or another of the three study setting, the homeless patient was met by the ethics team for qualitative interviews as well as

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one of the medical staff receiving him in order to enlighten the ethical dimension of their argumentation.

The interviews were conducted in order to better understand:

From the patient what do they expect from the hospital? How much were they concerned by their autonomy? What does the concept represent for them and what were the links between their health status and autonomy?

From the health care workers the goal of this interviews was to clearly understand how much they considered they have to respect patients' wishes and patients' autonomy. Were there the same questions and how do they argue about their decisions.

Then, a quantitative analysis of the socio-demographic and medical data and a qualitative analysis of the interviews content were preceded.

## • Results

54 patients were included: 19 on the first setting, 18 on the second setting, and 17 on the third one. Although samplings are too small to lead any statistical analysis, populations seem to be very different in between the three settings as regards the profile, expectations they talk about and the structures' health care strategy they propose.

- 1<sup>st</sup> setting : This is the most marginalized population : 74% of the patients live out on the street and for a long time (54% for more than 5 years). Alcohol dependancy is much spread: 89% are alcoholic. Moreover 60% have mental symptoms. Their requests deal with urgent somatic care and are much focused each time they come even if repeted. The autonomy they express takes place in the way they choose to stay or not at the hospital up to the point to be treated. Regarding the health care team, they express they feel disarmed facing such patients because of the lack of appropriate means and knowledge about how to take care of them. They think that their job is not about solving such societal issues. They let homeless people walking out even if not being treated. It's a way of respecting patients' autonomy but it's not really an ethical choice.

- 2<sup>nd</sup> setting: Differently with the first setting, only 11% of patients live out on the street. Most of them live in hostels or in uncertain accomodations. 67% of patients are illegal migrants. Their medical status seem less pejorative it sounds like they are consulting the same way they would have gone to their general practitioner. They express needs of general medical care. They come to this setting for their different somatic iterative needs. They also express that they appreciate very much the free, anonymous and easy access. Besides their medical demands, they look very concerned with their precariousness and estimate it to be a hindrance to their autonomy. Yet they don't expect the hospital to help them solving this kind of problems.

The institution firstly answers on medical grounds. To compare with the emergency departement, the health care team frequently recalls patients in order to try to create with them a social link. They hope that it will help them to be less isolated and vulnerable.

The way they respect homeless people's autonomy relies on a great acknowledgement of their personnel pejorative situations and on maximizing the doctor-patient relationship.

- 3<sup>rd</sup> setting: Less than 1% of them live out on the street but 83% of them present mental symptoms. They are coming to this specific service because of their mental symptoms. All of them have been guided toward the SMES. They expect the institution to take care of these issues. But their demands are not really precise, and we feel they could accept a wilder

health care strategy. In a way they also present themselves as needing some help to restore their global autonomy: psychic as well as social and personnel autonomy.

The answer from the structure is very adequate to this demand. The whole team is involved in it and composed of social workers, doctors, psychologists, psychiatrists. Patients are heavily accompanied and backed up on long periods.

Paradoxically, this is the way they restore their autonomy since the core point of the care is the quality of the doctor-patient relationship. Besides, patients are satisfied and subscribe to it.

- **Discussion and conclusion:**

Even if the study has some methodological limits, some points are particularly striking.

1. The "structure-effect": patients seem to go where they know they would get what they expect to. We can ask the question: Do the patients choose the institution according to what it offers to them? Or do the frameworks of the institution define the request?

2. This study questions how hospitals take care of the homeless people starting from what they claim to expect. It can help the medical staffs to rethink their practices and feed the thought about how and how far is it possible to enhance their autonomy.

2 conclusions we cannot decide between are available:

- Either: The less the patients are excluded, the more they ask for a complete, even very backing-up and interventionist care. More excluded people ask for a minimal care, focused on their somatic medical issues, and leave once they get what they came for. So we can conclude that homeless people are autonomous and know exactly what they want. From this point of view, institution must meet what is expected from it.

- Or: we can consider that it is necessary to implement whatever means in proportion to the depth of precariousness. The care must be adapted to homeless people's real needs, which are sometimes different from what they express. From this point of view, the care should be more interventionist and complete in emergency department. It encourages considering that promoting a special doctor-patient relationship is a useful first step towards autonomy enhancement.