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PERSPECTIVE

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Healing the homelessness, fixing a broken aid industry, and challenging the status quo: perspectives of a physician-activist

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ABSTRACT

Homelessness is among the most important problems in social medicine. While traditional studies provide useful answers (albeit for increasingly narrow phenomena), unique perspectives and first-person accounts hold potential to influence broader thinking about the field. Here, we provide a first-person account from physician-activist David Buck, a health policy expert and founder of Healthcare for the Homeless-Houston, on what it takes to tackle the homelessness epidemic, fix the broken aid industry, and challenge the status quo.

Introduction

Homelessness is among the most important problems in social medicine (Alowaimer, 2018; Mabhala et al., 2017; Toro, 2007). While existing scholarship on conditions of social distress is rich and multidisciplinary, most studies using traditional methods provide answers for increasingly narrow phenomena. In contrast, unique perspectives and first-person accounts – enriched by deep personal experience – can influence broader thinking about the field (Tsai, 2017). Combining scholarly discourse with narrative elements anchors the facts and data to personal meaning and motive (Reinsborough & Canning, 2017). These approaches are especially useful for confronting the unwritten assumptions and norms that may underpin an entire field of action or inquiry.

In our view, efforts to address homelessness within the existing "system" (e.g. identifying significant p values for publication in a journal, winning grants to fund a non-governmental organization) must be wed with attempts to discern the fault lines that run through that system's foundation. Are our endeavors truly aimed at *ending* homelessness, or merely providing us with a rewarding enterprise? What are the unintended harms of the humanitarian aid industry – and (how) can we repair them? When is the prevailing wisdom of medicine's rarefied circles perhaps not all that wise, and what should comprise our challenge to the party line? We do not purport to have all the answers. There is, however, a certain saliency to individual experience. Drawing on that to formulate these questions in a meaningful way is a useful place to start. Here, we[1] provide a first-person account from physician and activist David Buck, a health policy expert and founder of Healthcare for the Homeless-Houston, on what it takes to tackle the homelessness epidemic, repair a fragmented aid industry, and challenge the status quo in medicine.

Materials and methods

We conducted a live, semi-structured interview with Dr. David Buck on January 21, 2022. The interview guide was organized into four themes: (1) personal motivations for serving the homeless, (2) clinical and policy perspectives, (3) perspectives on the non-profit sector, and (4) perspectives on how medicine can change to better serve people experiencing homelessness. Dr. Buck did not know the questions or contents of the interview guide beforehand. Some parts have been omitted for relevance or lightly edited to preserve the confidentiality of some individuals and/or organizations named during this live conversation.

Results

Nicholas: We're going to talk a lot about your thoughts on homelessness, but let's start at the beginning. You worked with Mother Theresa in Calcutta. What's the story there?

In 1984, I was teaching at the Regional College of Education in Mysore, India. Long story short, that assignment ended early. I then had the privilege of volunteering within an orphanage and at the Center for the Destitute and Dying.

I had taken the MCAT[2] at that point and did not study for it. So then had the wonderful pleasure of taking it again [laughs]. I was interested in medicine, but also interested in some of the social factors that cause things like homelessness.

During orientation – it was just the Sisters and I – Mother Theresa asked us: "Who among you wants to change the world?" Internally I was screaming "Yeah! Me! I do!" But then I quickly caught on that, hey, wait, there's a trick to this. So, I didn't raise my hand. Then she said: "For all of you who want to do that, there's the door. Our task is much greater. Our task is to love one person at a time."

It was very humbling. That time was difficult in that I was assigned to carry the bodies from the Center to the basement where the transitional morgue was. That's really … that's a physical experience.

We alternated between the Center and the Orphanage. When we went to the orphanage, there were youth beggar's guilds where they would beat up the kids. The worse they looked, the more money they would take in, only to give it all back to the "pimp." There were many kids in the streets, profoundly neglected and abused, pulling themselves by the cracks in the sidewalk. They had not developed the body movements to walk. It was brutal.

I had a meeting with the Minister of Tourism about it. He said: "You're not from around here boy. We don't like your kind." And I realized I couldn't do anything. So I came back to the US and I knew I wanted to make a difference here at home.

> Nicholas: How did you follow through on that desire to make a difference?

I started volunteering with the Houston Catholic Worker House. I asked the Directors: "What is the biggest problem you have here?" And they said: "Healthcare access."

So, I set up two free clinics and one dental clinic while I was studying medicine and public health. I found that the root problem was *not* merely limited access to care. Rather, there was no *integration*. Whether primary care to subspecialty care, or healthcare to housing to food to identification cards to transportation. Each of those has their own silos and barriers. Homelessness is like a prison of these catastrophic failures at every level. Education, employment, the judicial system. It goes on and on.

Nicholas: I'm going to ask you to elaborate on that. You're preaching to the choir here, but I think a lot of people – medical professionals, even – would be surprised to hear one say "lack of access" isn't the fundamental issue.

Right. The root issue is there really is no "system" of care. What makes it so difficult is that the very people that need help in defragmenting all the different service lines are the same people that experience several layers of systemic failure.

Dr. A says, "You need to get your blood pressure medicine. What are you thinking?" Dr. B says, "You're using crack, are you an idiot?" And then Housing says, "Oh no you have to apply to XYZ, not ABC." It becomes Sophie's Choice.[3] You accomplish the one thing you can, but eight other agencies say you're noncompliant. So you feed your child, but you don't get your blood pressure meds for the month.

The sequelae of homelessness is brutal. After just 3–4 months, people experience physical trauma. Without support, psychological trauma develops. Is it any wonder people can't trust after this experience? So that's what this is for the homeless. It's a lose-lose scenario. That's why I set up Healthcare for the Homeless-Houston in the 90's,

> Nicholas: Let's talk about HHH. Was that when you started to realize your mission of building integrated services?

Well, I at least realized that it's a non-profit too. And by that I mean it has a Board, and the Board is responsible for the finances, and there are no financial incentives to work together with other service industries like housing, transportation, or employment.

Before I set up HHH, I spoke to [now deceased] Sally Shipman, the founder of the Coalition for the Homeless. I told her I didn't want to set up something with a separate board. It needed to fall under the Coalition for the Homeless Board. I said: "Programs with better outcomes have a one stop shop and integrate the social and medical resources. Let's do it like that." She agreed. But there was one board member – a lawyer – and his role was to address risk. He thought the risk was too great. I countered we had that covered: we had a host organization (medical school) and could subcontract services. The Coalition was also a governmental entity so the liability was very limited (in over two decades we have not had a single lawsuit!).

Well, you can tell we're a separate 501c(3). It didn't work. Sally and I remained friends and we tried to integrate services, but because there were different boards, we really couldn't align. And at the time, there were, you know, 150 non-profits serving the homeless.

> Nicholas: You're alluding to what I call "The Republic of NGOs," a rampant issue in my field, which is global health. If you go to Kathmandu, there's 5000 NGOs just in that city. If you go to Haiti it's over 9000. It's what Mark Schuller has called "Killing with Kindness." You've got all these places trying to do good, but you end up with fragmented care. People fall through the cracks.
>
> So, tension is, on one hand you want

to expand these desperately needed services, but on the other, does the world really need yet another NGO? My question is: when do we need a new organization for a given problem versus when do we need to unite existing efforts?

The answer is always the latter. We should strengthen infrastructure to build a true safety net system.

For example, take the 0–6 year age group. UHCOM is working on developing integrated population-based approaches to underserved groups. There's national legislation looking at pre-school programs, school lunch programs, all these evidence-based guidelines. We've identified some 50 different agencies working in the 0–6 age group, each of which provide just a few of the many best practices. So, that's a long answer to say these collective approaches are really helpful. A convener role in academia may be especially good for the academic – community partnerships.

> Nicholas: Independent silos vs. integrating services and working together is a big theme. So what does it take, then, to bring all the players to the table and get everyone to work together?

Leadership. And I mean, where do you see that happening these days?

The real answer is, if you want real leadership, we have to address campaign finance reform. Which is not partisan. Why is it that basic medical costs are prohibitive? Why is it that you have to go to Canada to get the same medication at a lower cost? It all goes back to campaign finance reform. Real leadership isn't where a vision is driven exclusively by giant and powerful companies but a broader group of stakeholders and communities – actual constituents. Why do we have such ineffective accountability for our "public servants" who have better health and pension benefits than their constituents? Can we expect NGOs to think more broadly about community goals and outcomes requiring collaboration when there are limited incentives? So we need to incentivize and hold our leaders accountable to and responsible for a public good. But our leaders are incentivized to get payoffs (contributions) from corporations because that's what keeps them in office.

We could pick on anyone. I've met with Mayors, judges, the commissioners, sheriffs, and so on. We've we reduced re-arrest rates, re-admission rates, and so on. And at the end of the day they say the same thing: "Those are fixed costs. Saving upstream costs doesn't impact me." There's been real quality improvement, but it isn't in their playbook. It isn't going to get them re-elected. It isn't their fault either – it's ours for not building a sustainable system that doesn't get further eroded each month with legislation

driven for large corporate profit. Profit isn't the problem, it just isn't enough of a driver for public good.

> Nicholas: So, what else have you done to pursue that vision of service integration?

I founded the Patient Care Intervention Center, PCIC,[4] and we have data from 1000 agencies to try and drive integrated health records. We have a community information exchange – all the social factors along with the medical risks. We have the public and private hospitals and systems, community health centers, food bank and 250 food pantries, shelters, and service centers – tons of data. And we integrate that under one health record driven by client or patient's values. Because then we could drive the kind of interventions that are based on tracking community level outcomes. The biggest risk for homelessness is prior homelessness. So, if we can start measuring those factors – educational or employment trajectories, for instance – we may really be able to impact health in a broader way.

> Mary: So you just mentioned that the biggest risk factor for homelessness is *prior* homelessness. How do we close the gap between someone becoming housed initially and then staying housed into the long-term?

We need better, affordable housing. But we also need livable wages. You've seen the transition in the job market and it's been much higher among the poor than the wealthy. Just the volatility of that sector has had a huge impact.

We also need safety. Take what Joe Benson said. He's a community health worker with Healthcare for the Homeless – someone that the HOMES Clinic[5] initially helped as a double amputee. He came into HHH through the student-managed HOMES Clinic, became housed, and eventually became the national consumer advisory board chair. He has told me many times, "In jail, you have an 8×9 cell. When you get an SRO – single resident occupancy – you get a 9×10 room. How come the only difference between the size of the room in jail and an SRO is you're less safe in an SRO?" I know people killed by gunshots in SROs. How do you stay housed or pull your life together in a situation like that? So we need jobs, livable wages, and we need *safety*.

> Mary: I'm glad HOMES Clinic has come up. What is the place of student-managed free clinics among the continuum of efforts to end homelessness?

Well, I think you pre-empted it in saying it's a continuum. There is no right or wrong. It's really about each person, each individual. Patient A may say, "Wow, its 10:51 and you said I would be out of here by 11. I'm gonna miss my bus. I hate you. If I don't

get to my appointment for an Identification card I can't get a job … " I'm sure you've experienced this?

Mary and Nicholas: Yes [laughs].

And then there are the others where you've objectively done nothing for them. You just feel like an abject failure. And yet, they're thanking you effusively for all that you've done.

We have to be sensitive listening to who and what matters to the client we're serving. "Okay, you're in a big hurry? All you're here for is the bandage? Got it." And that's what we do for them. Although, I would ask them what it would take to return again.

Because it is a failure for people to remain homeless. People say, "Oh I love this work because I keep seeing the same people year after year." *No, that's failure.*

Primary care is not built in a day. It's not built on one visit, or five. There's a longitudinal nature to it. That's what HOMES is doing. It's trying to build trust in a system that isn't trustworthy.

Nicholas: So how do we build a primary care system that is responsive to the needs of people experiencing homelessness?

Care based on values rather than problems.

Imagine your typical doctor's appointment: "Hi Mr. Patient, nice to see you today for your hypertension, obesity, substance use, your mental illness, oh and did I mention your obesity?" As I go on with that statement, you become less and less motivated for the behavior change that could improve your health. Now compare that to a values-based approach. Who and what is most important to you? And then you derive goals from that. That's based on cognitive behavioral therapy. That's where health behavior changes can really emerge.

The vast impact in health emerges from changing behaviors and medicine has not yet moved beyond the Flexner[6] age. Acute care uses the biomedical model, and, while it's necessary, we need to implement and reimburse models providing chronic and preventive care. That's where we have the opportunity to encourage others to be their best self and return the locus of control to the patient. That's what sets apart acute from chronic and preventive care. It requires a different set of skills and technology, such as a values-based record that tracks goals (medical and social goals) and assists in a new process in healthcare. This is what PCIC is implementing with social service and healthcare entities.

Nicholas: This kind of thing has been your message for a long time. Do you feel the rest of medicine has caught on?

I was once told: "You can be a real doctor and work with people with insurance" (wealthier people). Or,

"you could be a real researcher and work with genes and pharmaceuticals." But research on underserved care? Some would say: "that's not academic research." I was so irritated by those stilted interactions where some patients were seen as less worthy by physicians and by association our work was somehow second-class.

I said, "Really? This isn't research?" I mean, Nick, have you heard of Virchow? [7]

Nicholas: Certainly. "Physicians are the natural attorneys of the poor."

Exactly. "Where the dead lie thicker." For Virchow, it's among the poor. So those kind of moments really catalyzed that interest for me [in care of underserved].

Nicholas: Well, the value of that kind of work has certainly been recognized now, seeing as you've made it to UH College of Medicine as the Associate Dean for Community Health. What do you want to accomplish here?

Well, it may sound backwards, but we should be "failing better."[8] We should be trying to improve healthcare by using every visit to learn from our mistakes. Perhaps related to my passion and familiarity, the most regressive of all systems I know of is our health "system," and the most regressive within the health system is academics. It's the most entrenched. Developing a new medical school provides an opportunity to develop the innovative practices that could drive change.

The medical academic-industrial complex is often all about saying the right things. But at the end of the day we have to really ask ourselves: "are we developing new pathways of care besides the acute care pathways from the Flexner era, or are we just promulgating the same standards from the people who look like us rather than the people we serve?" So challenging that status quo is what brought me into academic administration. UHCOM is dedicated to training people from underserved communities to be effective leaders in underserved communities though a community engagement strategy.

Nicholas: Right. A lot of times the things that move your career forward are not the things that are moving medicine or patient care forward.

Precisely. I think what really moves us forward are the reflective practices we take every day. "How could that interview with Nick and Mary gone better? I should have asked them more questions, gotten to know them better." Or, "Wow, that patient I just saw. What could I have done better? They were really close to change, they were going quit smoking, but they left angry instead. What happened?"

Those reflective practices (individually and collectively), admitting to ourselves we need to fail better. And fail better in our personal lives. That's where real change happens. Not at the galactic level. I'm honored to be a part of UHCOM. But you have to go back to Mother Theresa's statement. Our greatest goal is to love one person at a time.

Discussion

Dr. Buck presented several perspectives of clinical, research, and policy value, summarized in Table 1. Some spotlight the ironic chasms that are created when well-intentioned efforts to fill service gaps are grossly uncoordinated. Others ask us to question the ethos of our own institutional cultures, interrogating whether we are chiefly concerned with improved outcomes or simply paying lip service to whatever is en vogue. All, however, underscore clear avenues for reflective action.

First, we must challenge funders at all levels (philanthropic institutions, the private sector, local, national, and international public grant agencies) to implement financing strategies that incentivize and reward collaboration among service organizations. Vertical programs have long been attractive to donors (ever anxious to quantify the "impact" of their aid dollars), but it is horizontal approaches focused on broad service strengthening and integration that ultimately produce the best outcomes (Basilico et al., 2013).

Table 1. Summary of major perspectives.

What is the biggest challenge in tackling homelessness?	• The root problem is that there is *no integration* of health and other services. • There are hundreds of non-profits but no financial incentives for one service industry to work with others like housing, transportation, or employment. • A homeless person will accomplish the one thing they can, but eight other agencies will say they are noncompliant. They feed their child, but they don't get their meds for the month. • Programs with best outcomes offer a one stop shop that integrates social and medical resources.
When should we start a new organization vs. uniting existing efforts?	• The answer is always the latter. We should strengthen infrastructure to build a true safety net system. • Example: PCIC is a community information exchange integrated under one health record. By measuring factors like educational or employment trajectories, we can impact health in a broader way. • Example: We've identified 50 different agencies working in the 0–6 age group. Each can provide 1–2 of the many needed guidelines for best practices, so collective approaches are critical.
How do we bring all the stakeholders together to truly achieve integration?	• Leadership. We need campaign finance reform because we need leaders who are accountable to communities, not corporate and donor interests. Profit isn't the problem, it just isn't enough of a driver for public good. • Can we expect NGOs to think more broadly about community goals and outcomes requiring collaboration when there are limited incentives?
How do we build a primary care system that is responsive to the needs of people experiencing homelessness?	• Care based on values rather than problems. • Ask the patient: "who and what is most important to you?" Then derive goals from that. That's where the health behavior changes can really emerge. • We need to implement and reimburse models providing chronic and preventive care. That's where we have the opportunity to encourage others to be their best self and return the locus of control to the patient.
How do we close the gap between someone becoming housed initially and then staying housed into the long-term?	• We need better and affordable housing, livable wages, and safety. • People are safer in jail than SROs. They've been killed in SROs. How do you stay housed or pull your life together in a situation like that?
How do we challenge the status quo?	• The medical academic-industrial complex is often about saying the right things. We must ask ourselves: are we developing new pathways of care besides the acute care model from the Flexner era, or are we just promulgating the same standard as the people who look like us rather than the people we serve? • It is a failure for people to remain homeless. People say, "Oh I love this work because I keep seeing the same people year after year." No, that's failure.
The things that move our careers forward are not always the things that move patient care forward. How do we really improve medicine?	• We should keep failing *better*. We should be trying to improve healthcare every day. • What really moves us forward are the reflective practices we take each day.

Second, we must resist the temptation to continue sprouting new organizations. Further proliferation of non-profit organizations will only serve to further fragment care. Instead, regardless of whether the financial incentives are there or not, we must reach across the aisle and build meaningful coalitions with existing players. A convener role may be useful for academic-community partnerships. Finally, change has to start from within. We have to reform our own professional culture to reward practices that are proven to improve key outcomes. This perhaps best starts with a high index of suspicion for any so-called "humanitarian" effort (including our own), being careful to critically appraise if one is merely developing their own enterprise without empowering the population they purport to serve.

Notes

1. In an earlier draft of this work, an anonymous reviewer suggested that, "researchers are inherently part of the research itself … a bit more about all of the people involved in the project would be in line with qualitative forms of inquiry." Therefore, supplementary info on all authors can be found in Notes on contributors.
2. Medical College Admissions Test.
3. Sophie's Choice is a film set in the Holocaust. A mother in a concentration camp is given an impossible choice: to decide which one of her daughters will be executed and which will get to live.
4. www.PCICTX.org.
5. Houston Outreach for Medical, Education, and Social Services (HOMES) Clinic is the only student-managed free clinic in Houston and serves people experiencing homelessness (Clark et al., 2003): www.homes-clinic.org.
6. "The Flexner Report of 1910 transformed … medical education in America with … the establishment of the biomedical model as the gold standard of medical training" (Duffy, 2009).
7. Rudolf Virchow was a renowned German physician, anthropologist, and politician. While perhaps best known as the namesake of Virchow's Triad, his investigation of the 1847 typhus epidemic is often credited as the origin of public health in Germany. He once famously said: "Medicine is a social science, and politics is nothing but medicine on a large scale" (Silver, 1987).
8. Phrase borrowed from Samuel Beckett's *Worstword Ho* (Beckett, 2014).

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Disclosure statement

NP and MF serve on the Board of Directors of HOMES Clinic, which provides free healthcare services to people experiencing homelessness. DSB is the founder of Healthcare for the Homeless-Houston and HOMES Clinic in 1999 and founded / serves as board chair of Patient Care Intervention Center.

Funding

Notes on contributors

Nicholas Peoples is a 2nd year medical student at Baylor College of Medicine and the Executive Director of HOMES Clinic, which provides free healthcare services to people experiencing homelessness. Prior to medical school, he spent four years overseas working for various global health programs. These included a mental health NGO in Nepal, a pediatric HIV/AIDS clinic in Malawi, and, while earning his MSc in Global Health from Duke University, an academic research group focused on rural primary care in China. Unexpectedly, these opportunities also exposed him to the ugly politics of international development – namely, that charitable organizations are often forced to compete with each other, rather than co-operate, because they are vying for the same sources of funding. This generated an intense interest not only in the medical and social problems that the poorest patients face, but in the fault lines that run throughout our own (sometimes misguided) efforts to serve them. That interest was the impetus for this manuscript.

Mary Fang is a 4th year medical student at Baylor College of Medicine and has served as the Associate Director of Operations at HOMES Clinic since her first days as a physician-in-training. She has also volunteered at Star of Hope (pre-Covid), where she served meals to women and children experiencing homelessness, and at New Hope Housing (during Covid), where she provided health education to women experiencing housing instability in weekly one-on-one sessions. These experiences have prompted her to lead numerous efforts to integrate medical and social services. Most recently, she co-created a program that trains medical students to volunteer as adjuvant social workers, enriching their ability to identify and address psychosocial concerns. Her interest in bridging patients with housing insecurity into longitudinal social services was a major stimulus for this manuscript.

David S. Buck is the Associate Dean for Community Health and Clinical Professor at the University of Houston's College of Medicine and holds adjunct faculty appointments as Professor at University of Texas and Rice University. From working in Calcutta, India, with Mother Teresa, to establishing impactful organizations across Houston, Dr. Buck has spent over 35 years reshaping how communities care for the underserved. In 1999, he founded and served as Chair and President of Healthcare for the Homeless–Houston, and his empathic and entrepreneurial spirit propelled him into pivotal roles as a co-founder and chair with Doctors for Change (2006–8), and the founder & chair of the Houston-Galveston Albert Schweitzer Fellowship Program (2007–16). His strides to improve healthcare expanded through his position on the founding board and later as Chair of the International Street Medicine Institute (2010–12), and on the Consumer Operated and Oriented Plan Advisory Board, at the request of the U.S. Secretary of Health and Human Services (2010–12). He is an innovator and thought leader, with over 25 published articles and

book chapters on improving the care of persons experiencing homelessness through health services research. Currently, he serves as founder and board chair of Patient Care Intervention Center, a nonprofit that leverages community-wide care coordination and technology to deliver resources to patients with complex social and medical needs.

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