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Street Stories: Fostering Humanism in Family Medicine

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Abstract

Introduction: Physicians frequently encounter social determinants of health such as homelessness, poverty, and addiction, that complicate clinical care and may contribute to emotional fatigue and burnout. While humanism in medicine has been associated with improved patient outcomes and physician well-being, it is often difficult to sustain amid systemic challenges. Medical education lacks sufficient opportunities for learners to engage meaningfully with marginalized populations in ways that reinforce humanistic values and advocacy. This study aimed to enhance humanistic engagement among residents and faculty through unstructured conversations with individuals experiencing homelessness at a community event.

Methods: Using a phenomenological approach, residents and faculty from a family medicine residency program participated in a community event serving individuals experiencing homelessness. After engaging in unstructured conversations with community members, participants submitted written reflections about their experiences. We analyzezd these narratives using thematic coding and consensus methodology to identify emerging themes.

Results: Three central themes emerged from the qualitative analysis: humanistic reconnection, challenging assumptions, and moving from understanding to action. Participants reported the experience challenged prior assumptions, enhanced empathy, and renewed their motivation to address the structural determinants of health in clinical practice.

Discussion: Direct engagement with individuals experiencing homelessness through community-based storytelling can reinforce humanism and promote advocacy, which may mitigate physician burnout. This study supports the integration of experiential, narrative-focused interventions into residency curricula as a means of fostering empathy and social responsiveness among family medicine trainees.

Introduction

Social determinants of health such as unstable housing, addiction, poverty, and limited social support profoundly affect patient outcomes and contribute to persistent health challenges despite medical care.[1] Barriers to care, including lack of transportation, limited access to healthy food, and inability

to afford medications, can lead to frustration and burnout when social needs cannot be addressed.[2] Humanism, emphasizing empathy, compassion, and person-centered care, strengthens the physician–patient relationship and improves outcomes, particularly in family medicine.[3-6] Residents caring for patients experiencing homelessness report empathy alongside moral distress, frustration with structural barriers, uncertainty about how to help, and exhaustion when social needs remain unmet despite clinical effort.[7-9] Humanistic engagement extends beyond values to behaviors such as active listening, curiosity about patients' lived experiences, respect for dignity, and advocacy-oriented action grounded in relationship.[3,4] Interventions such as service learning, reflective practice, and interprofessional education have improved empathy and advocacy, yet optimal approaches remain unclear.[7-9] This project sought to enhance humanistic engagement among residents and faculty through unstructured conversations with individuals experiencing homelessness at a community event.

Methods

Participants

The research team consisted of four residents and three faculty members from the Ascension Via Christi Family Medicine Residency Program. They self-selected to participate in the community engagement activity, contribute narrative reflections, and complete the thematic analysis.

Study Design

This qualitative study was approved by the Ascension Institutional Review Board. A phenomenological approach was used to explore how direct interactions with individuals experiencing homelessness influenced physicians' empathy and intentions to care for vulnerable populations.

The team attended a local community event serving individuals experiencing homelessness or housing insecurity. Resources included meals, street medicine, prayer ministry, showers, and hygiene supply distribution. The event was open to the public. Team members attended as community members and did not participate in resource distribution. Over three evenings in the fall of 2024, team members had conversations with adult (age≥18 years) attendees. Team members utilized a convenience sample and began conversations with attendees who were present and willing to engage. Project goals were explained and verbal consent was obtained. Team members developed sample prompts (Table 1) however, conversations flowed naturally and, in most cases, did not follow the prompts exactly. Conversations lasted from 5 to 20 minutes.

Following each event, team members debriefed. They discussed conversations they had, along with other observations, such as how attendees interacted with one another and the resources provided. After attending three events, the team discussed saturation and determined it had been met.

Team members then submitted written reflections describing interactions, emotional responses, and perceived impact on future patient care. They were given sample prompts (Table 1), but were free to write whatever they wished to share about their experiences. Reflections ranged from approximately 300 to 700 words. Narrative data were analyzed using inductive thematic analysis, in which codes and themes emerged from the data rather than being derived from a predetermined coding framework.[10,11] Reflections were independently reviewed by multiple team members who generated preliminary codes. Codes were refined through group discussion and clustered into themes. Themes were reviewed against original narratives to ensure coherence and fidelity to participant language. Discrepancies were resolved through discussion.

The team acknowledged that their clinical roles, interest in humanism, and advocacy orientation could influence interpretation. Prior to analysis, the team discussed assumptions and expectations related to

Table 1. Sample Conversation and Narrative Prompts

Sample conversation prompts	Hi, my name is ___ and am a local doctor who is curious about learning more about the lives of people in my community so I can be better equipped to serve them. I was hoping to hear some of your story today and get to know what makes you unique. I have some questions to get the conversation started but if you do not feel comfortable answering some of them that is okay, I really want to hear whatever you think is most important. 1. What brings you out to God N Dogs tonight? 2. Tell me a little bit about yourself. Where did you grow up? What do you like to do for fun? 3. What is something you think other people should know about you? 4. Where have you been spending the night most recently? 5. What does your community look like right now? 6. What is healthcare like for you right now? What happens when you get sick? 7. What has your experience been in the hospital or healthcare in general? 8. What are you most hopeful for right now?
Sample narrative prompts	1. What does humanism mean to you? 2. In what way(s) is humanism important in the practice of medicine? 3. Using your experience talking with a community member(s), please tell us how that has shaped your thoughts about providing care to patients. 4. Share about the community member(s) you talked to. 5. What did you learn from this experience?

homelessness and physician advocacy. During analysis, authors considered how their positionality as physicians and guests at a community event might shape interpretation. Reflexive discussion and consensus coding enhanced transparency and analytic rigor.

Results

The research team consisted of four women and three men, with a variety of racial identities including White, Black, and Asian. The residents were all in their second year. Faculty experience ranged from 5 to 33 years. Narratives were collected from all seven participants.

No specific demographic information was collected from community members to promote natural conversation and protect privacy. In total the team spoke with around 25 individuals. Community members were roughly two-thirds men, primarily White, and ranged in age from approximately 20 to 70 years. Their characteristics closely matched the demographics of individuals experiencing homelessness in Wichita, Kansas.[12] Three main themes emerged from the reflections (Table 2).

Humanistic Reconnection

Many team members described a transformation in how they viewed people experiencing homelessness. Through this experience they were renewed in their feelings of empathy, emotional engagement, and recognition of patients as whole persons. Prior assumptions such as “addicted” or “unmotivated” were replaced with “vibrant,” “resilient," and “savvy." One participant reflected, “There is a great temptation in medicine to see our patients solely in the context of the hospital… isolating their medical maladies from the rest of their lives." Another noted,

Table 2. Themes, Definitions, Findings, and Quotes

Theme	Definition	Illustrative findings	Representative quote
Humanistic reconnection	Renewed empathy, emotional engagement, and recognition of patients as whole persons.	Assumptions were replaced with appreciation of resilience, relationships, and personhood.	"Her hope is to be seen as a person rather than judged by her circumstances."
Challenging assumptions	Reevaluation of prior beliefs through direct interaction.	Participants reported reduced bias and greater understanding of relational poverty and social isolation.	"I assumed someone on the street would ask me for money, but all they wanted was connection."
Moving from understanding to action	Increased motivation to address social determinants of health through clinical and community action.	Participants described greater responsibility to advocate for vulnerable populations and influence systems of care.	"The real work comes from deciding that your own comfort and time is worth sacrificing to demonstrate the value and dignity of others."

> "I… did not expect those who were homeless or housing insecure to have years-long friendships with each other, to form lasting romantic relationships, [and] to raise children amidst this housing insecurity."

Participants described how burnout and systemic frustration can interfere with empathy, but the experience renewed their commitment to compassionate, patient-centered care. One resident summarized a conversation: "Her hope is to be seen as a person rather than judged by her circumstances." Yet another commented, "I felt a connection to the people I met."

Challenging Assumptions

Direct engagement challenged participants' biases and helped them reevaluate their prior beliefs. One wrote, "I assumed someone on the street would ask me for money, but all they wanted was connection." Another noted, "I realized how easily anyone could end up in this situation."

Many individuals were candid about their hardships yet sought understanding, not pity. The experience highlighted how relational poverty, being ignored or judged, can be as harmful as material poverty. Team members recognized the human dignity and individuality of those they met. One described, "I was reminded that everyone has a story." Another team member shared,

> "…I found myself listening intently as he recounted his story of addiction, family estrangement, friendship, revival, and hope. I hardly asked a question as he shared the joys and struggles… What struck me most was how eager he was to share his story with me."

This experience reinforced a common theme: despite hardship, individuals expressed a deep desire to be understood and valued.

From Understanding to Action

All team members described renewed motivation to address social determinants of health through clinical and community action. They expressed a desire to extend their efforts beyond the project and influence meaningful change. One wrote, "People who care, do. It doesn't have to be grand… it just has to be something." Another team member wrote, "Understanding their struggles made me want to do something." Participants described a deeper recognition of the need for holistic, trauma-informed care and a clearer

understanding of the physician's role in addressing social determinants of health. For example, one team member noted, “My role is not just to treat them, but to advocate for my patients." Another reflected,

> “There is nothing heroic about having compassion… . The real work comes from deciding that your own comfort and time is worth sacrificing to demonstrate the value and dignity of others."

Participants reported increased commitment to taking action–advocating for change in systems, policies, and day-to-day practice, rather than feeling sympathy alone.

Discussion

The group described humanism as recognizing the inherent value in all people, regardless of circumstance. Through direct encounters with individuals experiencing homelessness, this concept became tangible, challenging assumptions, reinforcing the importance of seeing the whole person, and highlighting the physician's role in addressing barriers to care. These findings align with prior studies demonstrating that experiential learning can enhance empathy, advocacy, and understanding of marginalized populations.[7-9] As advocacy is increasingly recognized as a core physician responsibility by organizations like the American Medical Association, American Board of Internal Medicine, and the American Academy of Pediatrics, experiences like this may represent a valuable approach to fostering humanistic practice and social accountability.[13-15]

Limitations

There are several limitations to consider. First, the project relied on self-reported experiences of individuals who agreed to participate. Those who declined may have had different perspectives, as may individuals who did not attend the event. Second, the physician team was composed of volunteers already motivated to explore humanism and may not reflect all residents or faculty. Their responses might differ from those of less engaged or less experienced clinicians. Nevertheless, expanding community-engaged learning opportunities within residency training may prepare physicians to deliver more inclusive, empathetic, and socially responsive care.

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Presentations

This project was presented at the Society of Teachers of Family Medicine Annual Spring Conference on May 4, 2025, in Salt Lake City, Utah as a work in progress popster. This project was also discussed as part of a scholarly topic roundtable at the Society of Teachers of Family Medicine Annual Conference on May 3, 2026, in New Orleans, Louisiana.

Conflict Disclosure

The authors declare no conflicts of interest or competing interests. This study received no funding.

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