The Costs of Caring: I-Poems as Illustrations of Moral Distress Among Professionals Working with Seriously Ill Homeless Individuals

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ABSTRACT
Both the recorded prevalence of moral distress among health and social service professionals (HSSPs) as well as the health needs of an increasingly older homeless population warrants further examination of how HSSPs experience and navigate moral distress when working with patients concurrently facing serious illness and homelessness. Through I-poems and iterative thematic analysis of 30 interviews, this study identified: (1) expectations versus reality, in which professionals contrasted advertised duties with actual tasks; (2) helplessness facing care constraints—felt experiences of powerlessness given current programming and funding; (3) disconnect from service users, how moral distress prompted bias in care decisions and avoidant behaviors in client interaction; and (4) reconciliation through community, or the social strategies professionals used to cope with or resolve moral distress. Findings from this study emphasize the importance of continued interventions for workforce development, adaptations to models of serious illness care for specialized populations, and efforts to create labor equity among healthcare and social services.

KEYWORDS: Moral distress, homelessness, serious illness, healthcare professional, social services

Homelessness and poor health are bidirectionally correlated—disability and chronic health conditions create accessibility needs not met by the housing supply and limit affordable housing options (Burns et al., 2021), and environmental hazards and stress related to housing insecurity are linked to higher rates of illness and mortality (Stafford & Wood, 2017). The prevalence of serious illness among people experiencing homelessness raises concerns about from whom and how care will be provided (Namian, 2019). Thus, it is crucial to expand

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comprehension of how health and social service professionals (HSSP)-- nurses, social workers, doctors, counselors, case managers, and housing administrators—experience and negotiate work with seriously ill homeless populations across housing and healthcare systems. By analyzing data collected across service sectors through reflexive thematic analysis and the creation of I-poems, this study offers unique insight into the felt experiences of HSSPs. The aim of this study is to illustrate professionals' perspectives of moral distress when serving homeless individuals with serious illnesses. We pose the research question: how do HSSPs experience and navigate moral distress when serving homeless individuals facing serious illness?

Background

Nurse and bioethicist Andrew Jameton (1984) coined moral distress to describe ethical dilemmas in healthcare in which "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p 6). Since then, the term has gained complexity through wider use, especially in public welfare services (Mänttäri-van der Kuip, 2019; Palma Contreras & Adriasola, 2024), including both in the contexts of healthcare (Lamiani et al., 2016) and homeless services (Morris et al., 2021; Peters et al., 2021).

Moral Distress and Serious Illness

A serious illness is any persistent or recurring health condition that (a) impacts the daily functioning of an individual and/or their caregivers and (b) increases mortality risk and reduces life expectancy (Ferrell et al., 2018). Moral distress among serious illness care professionals is well-established (Kerman et al., 2022; Latimer, Otis, Flaherty, & Ross, 2021) and has garnered increasing attention during the occupational risks, changing organizational protocols, and new iterations of patient suffering brought about by the COVID-19 pandemic (Baxter et al. 2022; Latimer, Fantus, Pachner, Benner, & Leff, 2022). The effects of moral distress on serious illness care professionals can lead to an increase in professionals' avoidance of patients, desensitization, and leaving the profession entirely (Latimer, Otis, Flaherty, & Ross, 2021). Professional well-being can be endangered by the nature of serious illness and end-of-life work, as it can aggravate existential anxieties (Back et al., 2016).

Within healthcare, facilitating aggressive treatment during end-of-life ranks among the highest morally distressing bedside encounters (Bayanzay et al., 2021; Epstein et al., 2019). Moral distress is significant across healthcare workers in both community and hospital settings. Organizational factors determine moral distress in staff (Lamiani et al., 2017). Reports on nurse and physician moral distress have revealed that direct patient care can be compromised due to a lack of resources and administrative inaction on the organizational level (Epstein et al., 2019). An international review of moral distress during COVID-19 found that, across multiple studies, the ethical climate of healthcare work settings impacted staff's sense of empowerment and, consequently, staff turnover (Riedel et al., 2022). Healthcare worker mental health is worse in the United States than in similarly resourced nations, a trend attributed to healthcare policy's effects on resource availability, workplace support, compromised patient care, and high caseloads (Plouffe, 2021; Riedel et al., 2022).

Moral Distress Among Those Serving Homeless Populations

The Public Health Service Act (Centers for Disease Control and Prevention [CDC], 2023) includes in their definition of homelessness all individuals who lack housing, without regard to whether the individual is a member of a family, whose primary residence during the night is a supervised public or private facility that provides temporary accommodations; who

reside in transitional housing; and/or who reside in permanent supportive housing or other housing programs that are targeted to homeless populations. (p. 218)

Homelessness services and the housing care continuum include street outreach services, emergency shelters, day programs for the unhoused, temporary housing, and permanent supportive housing. Distress, pressure, and hopelessness have been found to be prevalent among professionals working in the homeless service sector (Morris et al., 2021). Professionals frequently struggle with the same systematic forces that harm their clients, such as unstable and unaffordable housing (Petrovich et al., 2020) and low wages (Wirth et al., 2019). Additionally, service professionals who work with homeless populations are more likely than the general population to have first- or second-hand adverse childhood experiences (Aykanian & Mammah, 2022), including homelessness, serious mental illness, and substance use disorders (McGuire et al., 2021). Occupational hazards, including trauma exposure, can exacerbate the risks of developing mental health disorders (Wiewel & Hernandez, 2021). The housing care continuum faces high turnover and vacancy rates, with stress and burnout reported as part of workforce shortage over half the time (National Council on Non-Profits, 2023). Emotional burden and felt helplessness in the work (Peters et al., 2021), compassion fatigue, low wages, and a lack of training and support around trauma-informed care (Schiff & Lane, 2019) have all been accredited to burn out among HSSPs in the homeless sector.

Interdisciplinary teamwork within housing care systems can contribute to moral distress resulting from divergent professional ethics and training (Winnett, 2022). Housing professionals have reported moral distress when asked to protect patients' safety and well-being or enforce agency requirements around religion or work, particularly when professional training has emphasized client- or patient-directed approaches to care (Tiderington, 2019).

Study Aims

Since HSSPs serve an especially vulnerable population amidst the intersection of their own stressors, it is important to understand the ways in which moral distress affects them. One way to understand professional perspective is through I-poems (Koelsch et al., 2015), an analytic approach where poems are crafted using parts of transcripts where professionals reference themselves and their experience. Using I-poems allowed for an inductive exploration of moral distress within interviews that focused on objective patient interaction. Combined, I-poems and reflexive thematic analysis created opportunities to consider prevention and protection techniques for professionals working with people simultaneously experiencing serious illness and homelessness.

Methods

This study drew from HSSP interviews originally collected as part of The Research, Action & Supportive Care at Later-life for Unhoused People (RASCAL-UP) study, a partnership with a palliative care mobile outreach program for people experiencing homelessness in the United States. The overarching goal of this exploratory community-engaged mixed-methods study was to generate a meaningful understanding of the care of seriously ill people experiencing homelessness and the experiences of the professionals working with them across multiple sectors. The study was approved by University of Washington IRB (#00013488).

Sample

Data collection occurred between July and December 2021 by the first author. Via telephone or email, the PI contacted 92 organizations that partner in direct care with the HPC

team, identifying them through field observations and a review of chart documentation. Five contacts were no longer active, fifty-two did not respond, two declined, and three were lost to follow-up. Thirty interviewees from 28 unique organizations comprised the final sample, providing theoretical saturation to identify relevant themes and consider diversity within a complex sample (van Rijnsoever, 2017). Interview length ranged from 33-80 minutes ($\bar{x}$= 49.7, $x\sim$= 48).

Table 1
Health and Human Service Professionals Interviewed

Respondent	Description
1	Visiting nurse with large community hospice agency
2	Case manager with aging & disability services
3	Case manager at a medical respite program
4	Manager of an accessory-dwelling unit temporary housing program
5	Homelessness prevention case worker embedded within public housing
6	Inpatient palliative care social worker at large private hospital
7	Geriatrician overseeing Veteran's Affairs skilled nursing program
8	Supervisor at large men's shelter
9	Patient navigator at an outpatient cancer center
10	Nurse on an inpatient palliative care unit at a large private hospital
11	Visiting social worker with large community hospice agency
12	Case manager on forensic street outreach team
13	Case manager with aging & disability services
14	Nurse embedded in two single-site supportive housing programs
15	Social work director of large regional dialysis provider
16	Doctor on inpatient palliative care unit at large safety-net hospital
17	Social worker on inpatient cardiology unit at large safety-net hospital
18	Oncology social worker
19	Counselor at community mental health clinic
20	Manager at scattered-site and single-site supportive housing programs
21	Doctor at outpatient palliative care at large safety-net hospital
22	Social worker in outpatient/inpatient neurology at large safety-net hospital
23	Director of regional home and community-based services
24	Social worker at skilled nursing facility
25	Social worker in emergency department at medium-sized private hospital
26	Nurse at county correctional facility
27	Visiting social worker with large community hospice agency
28	Manager of single-site supportive housing program
29	Nurse in outpatient cardiology program at large safety-net hospital
30	Nurse embedded at large women's shelter

Data Collection

The PI conducted one-on-one interviews over a videoconferencing platform or telephone based on participant preference. Interviews were audio recorded and then professionally transcribed. All interviewees provided consent before the start of their respective interviews. In each interview, professionals were asked about their roles when interacting with

seriously ill people experiencing homelessness, facilitators and barriers to providing care to the population in their setting, typical patient trajectories in and out of their setting, the impact of COVID-19 on services, recommendations for enhancing care, and recommendations for improving service collaboration. As suggested in planning reflexive thematic analysis, interview questions were developed based on under-researched elements of existing literature (Terry et al., 2017), namely a lack of comprehension of service delivery longitudinally across systems of care. Participants were invited to share other experiences beyond what was asked, and conversational exchange was encouraged during interviews (Birks & Mills, 2022), particularly due to the PI's direct experience as a social worker with people concurrently facing homelessness and serious illness. Moral distress was not specifically inquired about but was emergent in many interviews.

Data Analysis

Guided by reflexive thematic analysis (Campbell et al., 2021), the PI conducted open coding on all transcripts while collecting data and after the data collection process to understand the depth and breadth of content. The full research team was comprised of a doctoral-level qualitative research course in which the PI was the instructor. Most of the students were pre-candidacy social work doctorate students taking the class as a degree requirement, with one doctoral candidate from biological sciences enrolled as an elective. The project was used as an instructive tool to walk students through the qualitative research process. All analyses were either completed in class or voluntary—any work outside of class impacted authorship order but not student grades. In class during March 2023, the team learned how to conduct open coding and transcript summarization with this data. Authors read and coded one to five transcripts each. The research team inductively developed a research question based on the initial discussion of transcript summaries. The seven student authors identified similarities in initial coding, such as topics like "vicarious trauma" and "burnout", and a review of initial themes generated by the PI, which included similar codes and the coding of emotion cues and language (e.g., "frustration", "upset," "apathy"). First in pairs, then as full class, the team then collectively engaged in theme development over two class sessions by aggregating and grouping new and existing codes, recoding, and revising the research question. All students elected to participate in manuscript formation after the class ended.

In addition to the thematic analysis of interview transcripts, four members of the research team created I-poems (Koelsch, 2015) from the "I" statements made by participants during interviews. I-poems provided a concise way to view statements participants made about themselves in alignment with the research question due to the focus of the interviews primarily being on participant's objective observations and thoughts rather than emotional experiences. Presenting this self-focused speech in a poem communicates the complexity of participant experiences and invites empathy among readers (Koelsch, 2015). Creating I-poems allowed the research team to centralize interviewee experiences of moral distress and their attempts to navigate that distress during analysis (Koelsch, 2015), thus providing a complementary analytic approach to reflexive thematic analysis driven by summative impressions of moral distress (Edwards & Weller, 2012). The team used a standardized approach to creating I-poems by reducing each transcript to short phrases beginning with "I", taking the smallest phrase needed to maintain the meaning of the statement. Self-referential uses of the pronouns "we" and "you" were also included in the poems. The order of statements was preserved between transcripts and I-poems. The PI and author RD checked that each poem was constructed following this protocol. The I-poems were then shared with all members of the research team to guide theme finalization. The final themes reflect a consensus view of all co-authors on what concepts were most represented across both forms of analysis.

Results

Four themes were identified through thematic analysis of transcripts and I-poems: (1) expectations versus reality, in which professionals describe moral distress emerging from a mismatch between normal and/or expected job function and actual interactions with seriously ill service users; (2) helplessness facing care constraints– an emotional consequence of system inequities at the heart of moral distress; (3) disconnection from service users-- circumstances in which experiences of moral distress prompted less patient-centeredness in clinical decision-making; and (4) reconciliation through community, in which professionals negotiated moral distress through action and advocacy through interpersonal and community-level connection.

Expectations vs. Reality

In this theme, HSSPs shared discomfort related to role clarity, whether related to serious illness in housing settings or behavioral health in health settings. This discomfort about role clarity sometimes led to overextending. HSSPs who expected to interact with seriously ill people experiencing homelessness expressed a sense of alignment in ways that other HSSPs did not. Most professionals did not perceive synergy between their understanding of roles and the expectations placed on them during care for seriously ill people experiencing homelessness. For some, setting a boundary in their role in response to system constraints was what generated distress. A medical director (R7) noted that, especially regarding psychosocial-spiritual care, unhoused patients "fall through the cracks" because systems were past capacity. He reported his department got frequent requests from community and hospital professionals who were stuck or burnt out, but his team would not have access to important details (e.g., medical record, care team) or existing rapport with the patient, so requests would be denied. Other professionals, like a director of a housing program (R20), shared how this dynamic arose internally within her agency:

> I can't tell you how many times
> we're like, "No, you need to keep them longer."
> We don't change dressings.
> We may not be there.
> We can't provide the services that those clients need.
> We don't get paid for that.
> I mean, I get it,
> I get it in some ways.
> We used to do what we called an emergency medical motel program
> We had too many instances where clients were not getting the care
> We had clients that were incontinent
> We had end-of-life clients.
> We can't be there, we couldn't.
> We were just like, "this doesn't feel –" I don't know what you would call it.
> We had a guy get hit, in a wheelchair – get hit by a car.
> We were just like, no, this doesn't work for us anymore.

Learning from past experiences where residents didn't get the care and safety needed, this seasoned professional communicated that part of her role was to advocate against premature discharge to protect her and her staff from overextending or for clients from getting inadequate care. While conscious of the challenges facing hospital staff and discharge planners, and considerate of the resident's right to self-determination, she noted that she and her staff could not be expected to provide wound care, toileting, or overnight support. There were numerous

interviewees who extended past role expectations. In many instances, this behavior was due to a lack of available resources and education. An outpatient palliative care nurse who worked with veterans (R10) spoke about the high prevalence of suicide among veterans during illness progression and functional decline. She expressed her team's distress: "I feel like we're following [patients] more closely than we have to. We have to prepare them, work with the hospice professionals, watch closely for suicide. We have to work hard to try to protect them." The director of a sanctioned tiny home settlement (R4) discussed how he and his staff delay leaving work at the end of their shifts, knowing that seriously ill residents will be alone at night. Inadequate housing and care options left them to cope with system inadequacies and perform outside of their job functions to fill the gaps. Along with other interviewees from supportive housing (R8, R30), he acknowledged the community aspect of housing and the attachments that develop among residents and staff, which amplified on-site care concerns.

Extending beyond one's defined role could also simultaneously buoy professionals amidst their distress– by addressing client needs but also honoring their own humanity. Three professionals became tearful, relaying direct care stories in which they enacted extraordinary care outside of the scope of their normal job duties. A case manager (R3) told a story of assisting a client in downsizing their storage unit after receiving a terminal prognosis, both as a meaning-making activity and to prevent any traumatic dispossession. Two nurses discussed going out of their way to provide comfort and relational care to patients who were frequently admitted– one sharing that she would dye a patient's hair for him during long hospitalizations (R17), the other noting that a recurring patient would be admitted wearing shoes that had been donated by the nurse's family (R29). Within these stories, professionals demonstrated distress in witnessing suffering, initial uncertainty about how to respond within their role, and a decision to go beyond. Few professionals acknowledged an expectation that within their role, they would primarily work with seriously ill and precariously housed patients. For these professionals, there was an alignment between their role in theory and their job functions in practice, which facilitated comfort and competence interfacing with service users. A home-visiting hospice professional (R1) reflected on her collaborations with supportive housing staff, noting that she was often more aligned in supportive housing with the typical functions of her role– providing comfort and education to loved ones than when working with wealthy patients living alone. Another respondent (R24) was a social worker in a specialty skilled nursing program for people living with HIV/AIDS, which had a legacy of serving people with homelessness histories facing multimorbidity. Her I-poem encapsulated this clarity of role:

> I spend much more time with them because
> they have these outbursts.
> My role over there is to be supportive
> to address anything, whatever is triggering them:
> I'm not taking my medication.
> I'm not doing anything.
> I don't like that person.
> I'll take a bath today.
> I think my role – our roles as social workers– we take on quite a big hat.
> I want soda.
> I have no soda.
> My Coke is gone.
> My Coke was stolen.
> I know they have a history of homelessness in their back story,
> We make them feel that way, like this is their home.

Helplessness Facing Care Constraints

A second central theme across interviews was that professionals expressed helplessness in performing their duties when limited resources and a polarized political environment inhibited their ability to address unique patient needs. A mismatch between population needs and system offerings, colored by meritocratic values, created emotional suffering and angst among respondents. A case manager from aging and disability services (R2) shared that he often feels like he's "running into brick walls" and experienced a sense of dread returning to work, stating "you're constantly just doing the same thing over and over again for the same person because nothing sticks. It's really demoralizing at times." An inpatient palliative care social worker (R18) with a background in geriatrics shared that when starting her job, she was surprised at how young the patients were who experienced homelessness alongside serious, life-limiting illness. In the face of this "discouraging" reality, she shared, "They [other medical departments] call us because there really aren't any options. We at least get the conversation started…we mainly focus on goals of care." This social worker noted that due to her team's capacity and the nature of these referrals, brief care goal conversations and "empathy" are all they can offer. The I-poem of another inpatient social worker working in oncology (R22) captured the emotional impact of working within such extreme constraints. She shared an exhaustion and downheartedness in advocating for patients on an interdisciplinary team without placement options or proper resources:

> I was like, "I hear you."
> I was like, "if you don't want them, that's fine"
> I'm like, "She doesn't want them"
> I was like, "She doesn't need an address."
> We only get as much as they choose to share,
> I can support her getting her to the address
> I don't have the bandwidth to solve her housing needs.
> I mean, it doesn't feel good–
> We don't have all the tools.
> I think it's been the hardest,
> getting people placement.
> I know.
> I was like, "I think I'm really tired."
> I just kind of took it easy this summer.
> I mean,
> I was still working,
> I was just processing all the sadness that was built up.

The social worker shared that her role on an interdisciplinary healthcare team is often to challenge the barriers to patient care access, but that barriers so frequently felt insurmountable that they required intentional self-care and detachment from work to sustain. Similarly, an outpatient mental health professional working with homeless populations (R19) reflected that the history of residential mental health treatment was "sad" and seeing people "utterly bored" and "overmedicated" early in her career as a motivator to advocate for better placement options for people experiencing chronic homelessness and mental illness. Even after three decades of nursing work, she expressed that she continued to feel distressed at the state of skilled nursing and adult family home placement for people aging with homelessness histories and serious mental illness: "If that was me, shoot me. Just put me out of my misery. I think everyone needs to feel valuable, and we've kind of quarantined them."

Other professionals noted that homelessness response is a divisive political issue that informs the demands of professionals in care environments. A nursing student working as a case manager in a respite program (R3) described working with people receiving palliative care and end-of-life services as "one of the tougher experiences" he had as a healthcare professional. "Getting a little emotional," he said, expressing anger at the lack of resources and support and confusion about political opposition to homelessness services: "We're dumping thousands of dollars just sending them back to the streets." A nurse working in the county jail (R26) shared that punitive approaches to homelessness, addiction, and mental health crises limit her abilities to provide quality care to people facing degenerative conditions:

> We do just enough to keep people from crashing.
> I just want to be able to provide more education,
> to be able to convey more care.
> I used to be able to,
> even just with my words and body language.
> I'm supposed to keep as much distance
> from people as possible in providing care.
> How do I balance this?
> I just tell him, "In a different setting
> I could have more of a conversation with you about options.
> I can't do that here."
> I have compassion for the nurse or the whoever
> who thinks this is just too hard to see,
> I can understand why somebody
> has some moral distress around that.
> I think that after years of working in housing services,
> it's difficult for me to adapt.

Several professionals across systems corroborated the benefits of transformative justice and harm reduction approaches in reducing their own internal conflict as well as improving patient care and acknowledged feeling a lost sense of hope when this approach was not taken.

Disconnection from Service Users

Beyond the felt experience of moral distress, a third theme in interviewee narratives described how one of the consequences of sustained moral distress was an impaired ability to be patient-centered as individuals. Forms of withdrawal and avoidance were observed, whether through job exits, apathy, or projection. HSSPs primarily described how apathy and fear promote avoidant and disengaged behavior in direct care. Multiple interviewees working outside of healthcare spaces discussed experiencing--and observing in their peers--an avoidance of clients or residents once a health event changed their trajectory. The outpatient mental health professional (R19) shared that when a recent client of hers received a terminal cancer prognosis, residents and staff of the shelter she resided in wanted to provide her end-of-life care, but this was beyond the bounds of the shelter's policies and protocols. Despite this conflict's emotional effects on the client and the opportunities for the professional to be a support, she shared, "The palliative care team was called in, hospice was called in, and then they kind of come in and take over. I didn't deal with her as much…it's just kind of their zone." Ambiguity and over-extension of roles may discourage professionals from staying involved once referrals to palliative care services are made. At the time of his interview, the respite case manager (R3) discussed that the initial design of respite was to assist with transitions out of hospital for more acute issues like wound care, but when referrals trended toward people with end-stage chronic

illnesses, respite staff struggled to successfully partner with hospice and palliative care services. He shared that once he and other respite staff "wised up" to the components of successful end-of-life referrals, they experienced a sort of institutional amnesia: "It's not wanting to talk about it. It's that I just let go of a lot of stuff. It's like my bank of resource information in my head, experiences of some stuff, I just kind of let go of what's not useful anymore." Professionals no longer kept track of how to care for palliative care patients after referring services out.

Sustained emotional burnout was described as a precursor to staff turnover, or alternatively, apathy among those who stay in their roles. The social worker at the skilled nursing facility (SNF) (R24) shared that in her prior job as a hospital discharge planner, patients who were simultaneously seriously ill and housing insecure were often "dumped" at skilled nursing when it was determined they needed a higher level of care. She shared that in this role, telling patients, "They have a bed available, goodbye!" was dehumanizing because of what is "lost" in the transition for people who may have traumatic displacement in their histories—the guiding factor in her leaving the position and going to work where she could have more long-term relationships with clients.

In addition, some professionals shared scenarios where they found themselves projecting their own values or prioritizing their own comfort due to their levels of moral distress. The I-poem of a nurse on an inpatient cardiology unit (R17) exemplified this trend:

I've never really asked them, like, 'do you want to be here when you die?'
I don't think that he didn't want to be with us
I don't know if that would've been his choice.
I don't know that he even would think about that.
I remember, like he was born at [hospital], you know? We kept him.
I feel better if they come back and pass away here
instead of alone in their apartment, you know?
That might be selfish, maybe they want to,
but that's how I feel.
I just don't want them to not be with anybody
or not be getting the care they need if they're on their own.

This professional had built rapport with frequently hospitalized patients over long spans of time. In the absence of documented care preferences and patient decisional capacity, healthcare teams may need to make clinical decisions informed by historical knowledge of the patient. However, these HSSP observations demonstrated how, in retrospect, professionals sometimes worried their emotional responses impacted the fidelity of best practices. Similarly, a nurse from a cardiology clinic (R29) reflected on the lack of preparation her medical colleagues have in managing the socioemotional experiences of providing patient care in safety-net healthcare. She described "listening to the patient" and "respecting free will" as more emotionally and pragmatically challenging than hierarchical, intervention-heavy responses, noting, "Medicine is not built that way. We've completely lost public trust. Most of our professionals are coming from a lot of stability and education and advantage, so it's 'I know all this information and you don't know anything' attitude."

Reconciliation Through Community

Professionals did not always succumb to moral distress, sometimes finding ways to successfully manage and negotiate the institutional constraints at their root. In this fourth theme, HSSPs shared how they overcome moral distress by identifying allies and, on a larger scale, connecting with a politicized community. Identifying allies within the work was one tactic for persevering. The cardiac clinic nurse (R29) shared that in her role, she educates healthcare

professionals on and reminds them about harm reduction and social determinants of health and builds a "subculture" within the clinic of people who can represent those values in clinical decision-making and patient care. An aging and disability services case manager (R2) relayed a story of coming back from leave to meet a client's "phenomenal" new housing case manager and allying with her to expand caregiving for residents throughout the building. A medical director of an oncology program (R16) informed the interviewer that they've started "moral distress wellness rounds'" in response to the distress experienced by staff– particularly nurses, social workers, and care managers "who feel the most pressure" to reduce hospitalization, successfully manage symptoms, and streamline referral and discharge. The respite case manager (R3) empathized with patients through his own negative healthcare interactions as a queer man, noting that his empathy guides him toward collaborating with professionals who offer "more understanding, more tolerance, more time and less pressure."

The I-poem of a director of a supportive housing program (R28) with an extensive history in the industry shared that moral distress has motivated him to cultivate partnerships that reflect his philosophies and the needs of his residents over the course of his career:

> I think we're meeting with the fire department this week.
> I've got one of the only two buildings, I was told,
> We've got a special grant– it allows us to have undocumented folks
> and low-level sex offenders.
> I'm on the phone with their social worker
> That low-barrier entry, it's the reason why I actually work here.

HSSPs shared that since the COVID-19 pandemic began, there has been increased visibility regarding burnout and moral distress as they relate to labor rights, equitable pay, and shifts in acuity and demand. While some professionals spoke about this dishearteningly, many shared how directing their energy and insight into political advocacy both on and off the clock. The I-poem of a dialysis social worker (R15) who had recently moved to the region demonstrated how having a community of advocates alleviated distress:

> That's why I moved here.
> You need to be an advocate, but
> you reach a point where you just feel like you're banging your head against a wall
> because of the politics of the place.
> We just wanted to live somewhere where we could actually feel like
> we could do some good.
> I think it was a point of reaching a sense of burnout in a political system
> that felt very red and very restrictive.

After identifying the legislative-level barriers to resolving moral distress, this social worker was willing to relocate to a less restrictive political environment so that she could continue providing quality care with a sense of hope and community.

Discussion

Through thematic analysis and I-poem creation of HSSP interviews, four main themes arose. In the first theme, expectations versus reality, respondents described a disconnect between their daily care provision and their official job duties. These interactions illuminated a strain between professional morals and organizational boundaries, such as the inability to accept new patients, collaborate in care, and set interpersonal boundaries, like honoring one's personal needs. Regardless of role or setting, a prominent experience among HSSPs was extending

beyond intended or expected duties. Role clarity has been a documented challenge in safety-net healthcare settings among social workers (M. Moore et al., 2016), nurses (Lankshear et al., 2016), and doctors (Mills et al., 2015), as well as in housing and homelessness support services (Lemieux-Cumberlege & Taylor, 2019). Housing care continuum professionals also experience conflict in preserving their own boundaries and wanting to help residents (Tiderington, 2019). In the face of continued organizational obstacles and institutional unresponsiveness, direct care professionals across systems are likely to experience this role drift. Professionals discussed how their teams set necessary boundaries in their settings to protect from role drift and resist "patient dumping." However, doing so also generated moral distress. The impact of programmatic boundaries, such as strict eligibility requirements on direct care professionals, has been recently observed during times of resource scarcity in the height of the COVID-19 pandemic (D. Moore et al., 2022; Riedel et al., 2022). Role rigidity and system constraints can also impact perceptions of quality in care– adults experiencing homelessness often perceive medical staff as uncivil and stigmatizing when enacting such boundaries (Woith et al., 2016). Though the subfield of palliative care uplifts humanizing values like patient-centeredness and holistic perspectives, palliative care patients experiencing homelessness still note overlooked psychosocial complexities and reduced autonomy during serious illness unless professionals have adequate training and consultation opportunities (Klop et al., 2018). Professional licensing bodies and healthcare institutions' ethics committees can benefit from increased attention to professional and patient experience to revise professional and institutional protocols. Exceptions among the sample were those located in specialized services specifically for people with concurrent serious illness and housing challenges, reflecting how role clarity and expectation alignment may reduce moral distress.

In the second theme of helplessness facing care constraints, professionals detailed the emotional toll of witnessing and enacting barriers to care. Professionals reported feeling under-resourced, facing missing levels of care that might disrupt diversion and recidivism rates, all while holding emotional space for their clients and themselves through grueling circumstances. Professionals compensate for the lack of public health resources through their own efforts: connecting disadvantaged patients to charities, negotiating payment plans, and referring uninsured or underinsured patients to specialty care programs (Armin, 2019). Self-care methods such as meditation, religious observance, and reflective exercises have been seen to foster resilience among serious illness professionals (Guzys, 2021). However, self-care practices neither address the systemic causes of moral distress nor are deployed by professionals in moment-to-moment coping (Guzys, 2021; Koonce et al., 2023). Direct means for coping with moral distress and building moral resilience include introducing ethical education in undergraduate and professional learning programs (Palma Contreras & Adriasola, 2024), improving moral climate, and teaching advocacy skills (Guzys, 2021). Moral courage– an ability to overcome personal challenges in the service of a process or outcome with moral worth– has been an indicator of nursing student success with homeless patients experiencing serious illness (Nash et al., 2016). Professionals also stressed the importance of workplace environments where moral courage could be facilitated and invited through emotional debriefing, healthy external boundaries, and collaboration (Back et al., 2016; Soerensen et al., 2023).

In the third theme, professionals displayed how moral distress deterred patient-centered care by promoting emotional disengagement. One way this took form was through "institutional amnesia," in which other members of the care team emotionally disconnect from their relationship with patients and their role as caregivers. Research on relational healthcare priorities of people experiencing homelessness has emphasized the importance of feeling cared for (Biederman et al., 2014) and working with non-judgmental and non-ambivalent professionals (Henderson et al., 2022), but professionals in this study described relational avoidance when patients experienced a health event that shifted their care trajectories. The

stressors that can cause hopelessness can also affect behavior. Transitioning into an apathetic state has also been recorded in the experiences of hospital social workers who work with the homeless, as they deem it necessary to maintain life-work boundaries in an acutely distressing work environment (Winnett, 2022). The burden of responsibility for addressing apathy is often placed on individual workers (Kavalieratos et al., 2017). However, the increasing normalization of moral distress may offer opportunities to address organizational and structural sources of these consequences (Back et al., 2016). In addition to endorsing individual actions to promote resilience among HSSPs, healthcare leadership, and medical education can build ongoing structures for meaningful peer connection to decrease stress and promote the identification of structural causes of burnout (Vercio et al., 2021).

Biomedical ethicists have advocated against a long-standing culture of "doctor knows best" (Popowicz, 2021). In scenarios of heightened emotion, HSSPs in this study reflected on instances where they made or observed biased care decisions guided by hierarchical cultural standards or their own distress rather than identifying patient wishes or considering a patient's support system. It is true that professionals may need to make treatment decisions based on information gained from valuable and long-standing professional-patient relationships (Henderson et al., 2022), particularly given the frequent absence of documented care goals among homeless populations (Kaplan et al., 2020). However, moral distress may generate bias or offer opportunities for professionals to project their own wishes onto the patient. Successfully preventing and rectifying knee-jerk care decisions may require training and continuing education specifically oriented toward homeless populations on topics such as serious illness communication (Davis-Berman 2016), implicit bias (Torino & Sisselman-Borgia 2017), and trauma-informed care (Stillerman et al., 2023). Such training may assist in orienting professionals to patient wishes and needs prior to crisis and promote a culture of equity and patient-centeredness. Specialist consultations and opportunities for collective reflection may successfully reduce moral distress (Morley et al., 2021). Cross-sector collaborative care models in which health professionals visit residents or consult with profesionals in the housing care continuum have shown positive outcomes for mental health (Barker et al., 2022), substance abuse treatment (McLaughlin et al., 2021), and maternal health (Kropp et al., 2023)– such models that focus on palliative care may reduce moral distress and subsequent biased action.

The last theme, reconciliation as a community, detailed how social ties helped professionals stave off, cope with, and resolve moral distress. Such interpersonal strategies included allyship with professionals who share values, using moral distress for institutional movement-building, and engaging in political action on a larger scale. Cultivating a sense of shared values and comradery increases positive coping and sustainability in a workforce (Garcia-Jorda et al., 2022; Lamb & Cogan, 2016). Professionals working with homeless populations often agree on the values of believing in the capacity for change and personal accountability to be an advocate (Peters et al., 2021). Reinforcing values-based commonalities on an organizational level can build collective resilience (Garcia-Jorda et al., 2022), and witnessing organizational change can reinforce professionals' sense of themselves as part of a collective effort toward justice (Peters et al., 2021). Professionals emphasized a shift in work culture within the housing care continuum and contextualized the moral distress of staff within their own economic precarity. Social service professionals in housing and homelessness care are given low wages relative to regional cost of living and education level (Wirth et al., 2019). Providing quality care for seriously ill people experiencing homelessness requires public health professionals to work "at the top of their license," which, when aligned with pay, can promote functionality on interdisciplinary teams (Higgins & Geld, 2021). Paying a living wage to public health and human service workers will, therefore, likely reduce moral distress and its consequences. Due to evidence correlating moral distress with professional training level, establishing a workforce development strategy could lead to better valuations and resources for workers. The implementation of monetary incentives for micro-credentialing and workplace

development in serious illness could offset economic precarity and offer career growth opportunities (Murphy et al., 2023).

While moral distress is accompanied by physiological and psychosocial stressors, it can also mobilize social justice efforts in the workplace and beyond (Peter et al., 2013). The conflict between the values of the individual and the institution invites space for critical discussion about the workplace's moral habitability (Peter et al., 2013). This dialogue can be used to advocate for budget prioritization (Bittle, 2022), training opportunities (Garcia-Jorda et al., 2022), reduced workload (Baxter et al., 2022), and leadership decisions (Peter et al., 2013). Giving each staff member a legitimate voice through non-hierarchical shared decision-making models reduces overall moral distress, as demonstrated in the case of nursing staff (Epstein et al., 2019; Peter et al., 2013; Small et al., 2019). Healthcare education can promote moral courage and moral efficacy through a greater curricular focus on ethics, advocacy strategies, and the development of internal tools for assertive communication and self-regulation (Rathert et al., 2016).

While professionals may choose to engage in individual or organizational efforts to create the conditions for moral courage, there is necessary advocacy to be done in the healthcare system at large (Koonce et al., 2023). HSSPs are frequently aware of their patients' experiences of social injustice, but time for social justice engagement is not always included in their workflow (Small et al., 2019). When care can be reflective and responsive to patients' sociopolitical contexts, professionals resolve moral distress (Small et al., 2019). Amidst deep moral distress, communities have advocated for greater resources and increased institutional accountability to "move upstream" in addressing public health issues like displacement and racialized health disparities (Baxter et al., 2022). Healthcare administrators in safety-net hospitals, most likely to serve patients left behind in policy changes such as Medicaid restrictions (Boehm et al., 2005), have a responsibility to resist and divest from structures that limit patient choices (Shdaimah & McGarry, 2017). The creation and preservation of affordable, accessible low-barrier housing, increased Medicaid Section 1115 waiver programs, and funding for evidence-based programs such as critical time intervention, medical respite, and social needs screenings have all been recommended policy interventions (Garcia et al., 2024) that may reduce workplace burdens, role strain, and hopelessness among HSSPs.

Limitations

Sampling was restricted to one urban county in the United States, limiting generalizability. Interviews focused broadly on patients with serious illnesses and complex care management, but the association with the HPC team may have skewed interview data based on knowledge and perception of what palliative care is. HSSPs were not asked for length of time in the profession, demographic information, or depth of familiarity with palliative care during interviews. Because this information is not known across all participants, it is indiscernible how these factors influence experiences of moral distress. Though the length of experience and individual beliefs were recently identified in a systematic review of moral injury (Beadle et al., 2024), no known studies explore how professionals' identities and personal affiliations influence community building and other interpersonal strategies for coping with moral distress. Professionals in residential drug treatment and detox programs were contacted for participation due to their relevance but were not represented in the final sample. The research question was developed inductively, and moral distress was not directly asked about in the interviews. While offset by the inclusion of thematic analysis, I-poem formulation abstracts transcript data, potentially rendering experiences of professionals indistinguishable from their perception of others' experiences, including those of patients, clients, and residents facing multiple structural vulnerabilities. Considering these limitations, future research that sets out to explore moral

distress may wish to consider methods that engage both professionals and their residents, clients, and patients.

Conclusion

Professionals working with homeless and seriously ill populations are tasked with witnessing and responding to a unique intersection of suffering. Whether in serious illness medical care or homelessness response services, there is a contrast between professionals' role expectations and the demands and realities of their actual daily work. professionals may feel helpless against what is out of their control-- treating late-stage disease, securing or preserving housing stability, and navigating patient wishes with barriers to care and care gaps. Professionals experiencing moral distress may respond emotionally, through avoidance and through knee-jerk actions in ways that may determine patient care experiences and outcomes. Professionals engage in actions and strategies to reconcile moral distress through identifying professional peers with shared values, developing meaningful client relationships, advocating within their agencies and organizations, and taking political action. Safety-net hospitals, homelessness response systems, universities, and local and state government services can address moral distress and enhance homeless serious illness care through specialized interventions and models of care, advanced training, and education opportunities to prepare the workforce for serious illness care for homeless populations, labor equity and incentives for healthcare and social service professionals, and platforms for political representation and voice to continue toward health and housing justice in our communities.

Declaration of Interest

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