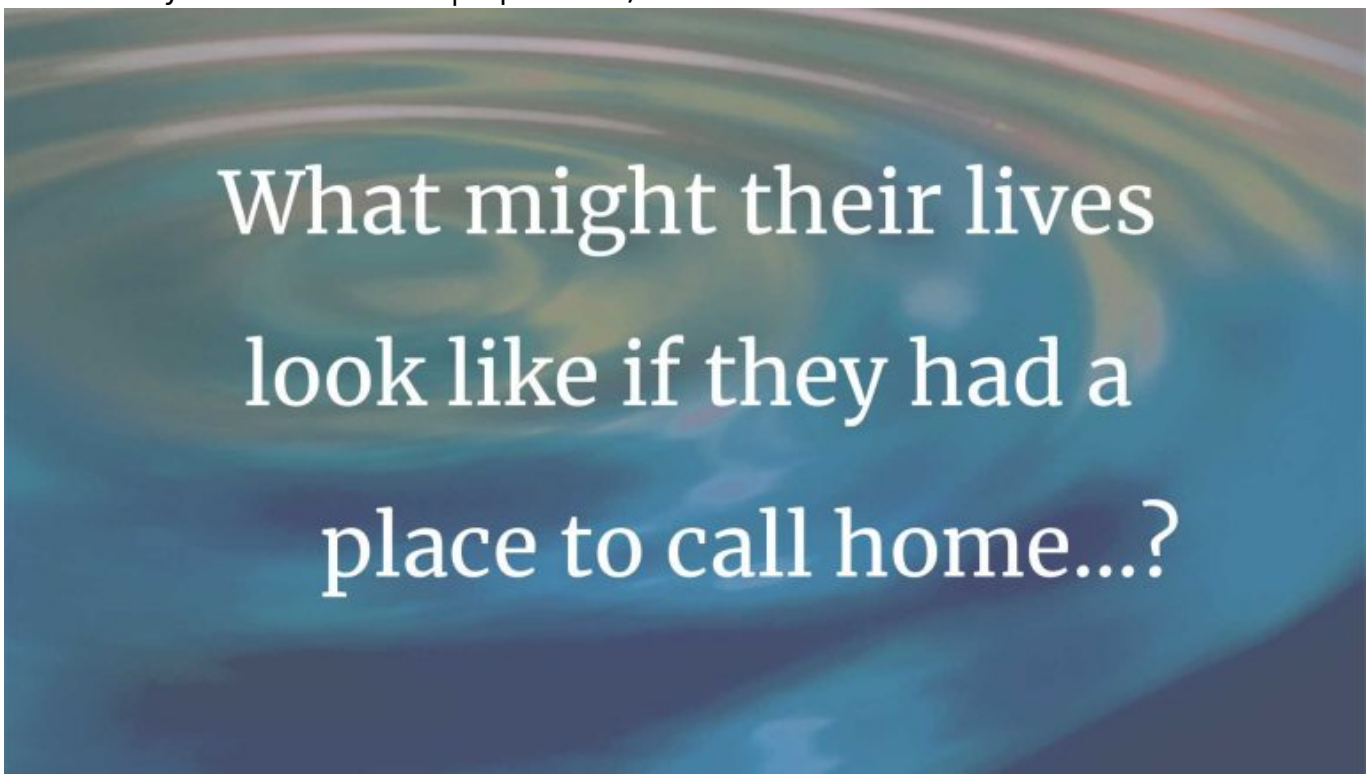
The Medicine We Don’t Prescribe

Category: Stories
written by Travis Walker | April 10, 2026



I step into the back of a van on a chilly fall day. I’m a family physician; with me are my medical assistant, Lori, and the front-office representative, Maria, from our federally qualified health center in Reno.

This van is our center’s mobile clinic—one exam room, a point-of-care lab and a front desk squeezed into a space no bigger than a typical bathroom.

Today we’re visiting a family shelter, as we do every week. A handful of colleagues and I take turns stepping away from our regular clinics to see these patients—individuals working to get back on their feet after suffering from chronic homelessness, unsafe housing, addiction and abuse. Different lives, suspended in the limbo between survival and security.

From the van’s back window, I see a yellow school bus rumble to a stop nearby the shelter. A handful of children climb aboard—some rubbing their eyes, some clutching backpacks donated by strangers—and I wonder how well they slept last night.

After the bus leaves, a steady march begins: individuals knocking on our van door to be seen. Some have appointments, some don’t; but no one is turned away. There are always new faces, some regulars, and notable absences—once-frequent visitors, no longer at the shelter. I’m left wondering whether they found somewhere to call home or are back on the street.

Lynn comes in with her three-year-old daughter, Penny. Despite living from couch to couch, Lynn has kept her daughter vaccinated, fed and well cared

for. Penny is healthy, but words sit unformed behind her shy smile. The on-site daycare staff has flagged a speech delay.

I kneel down, meet her cautious eyes peeking around her mom, and feel the weight of what I cannot change in a single visit. The best I can do today is to offer a referral to a speech therapist. Penny's too old for the state's early-Intervention program, but we can try to connect her to resources and help provide transportation.

Next comes fourteen-year-old Maddie with her mother—both anxious in different ways. Maddie speaks openly about her very active sex life. We spend most of the visit talking about consent, boundaries, contraception and sexually transmitted infections—a conversation punctuated, on her side, by profane, defiant interruptions.

"I don't want to quit fucking…it feels good!" she says. "I like it! You can't stop me."

"I get it. I'm not here to stop you," I tell her. "I want you to have choices. A pregnancy right now would take away a lot of your choices."

For a moment, instead of staring me down, she fixes her eyes on the floor; I hope this means that I've struck a chord.

Her mother watches silently. I get the sense that she's exhausted, not from moral judgment but from the sheer task of raising a child while trying to secure a future for both of them.

A seventy-year-old woman, Janie, arrives next. Her diabetes has been uncontrolled for years—no surprise when your life is divided between shelters in three states and marked by long bus rides and the faint hope that someone will refill your insulin before your blood sugar spikes again.

"I'm sorry for the inconvenience," she murmurs.

"You don't owe me an apology," I say, feeling like I owe *her* one. What she needs is stability, which I can't provide.

Seeing patient after patient, I can't help imagining what their lives might look like if they had a place to call home. How many of their conditions would dissolve or soften, given shelter and security? How many of their crises are symptoms not of disease but of displacement?

My mind drifts to Dr. H. Jack Geiger of the Delta Health Center in Mound Bayou, Mississippi. In the mid-1960s, he used the clinic's funding to buy groceries for hungry, malnourished families. When federal officials, on the governor's orders, told him to stop—insisting that healthcare money was not for food—he famously replied, "The last time I looked in my medical textbooks, they said the specific therapy for malnutrition was food."

How novel.□□ How simple.

How obvious.

Could the solution to homelessness be just as straightforward? A home?

Not setting up a requirement to "fix" everything else first—not demanding sobriety, mental-health treatment or employment—but simply giving someone a key, a lease, a place that's theirs. Giving them a foundation before asking them to rebuild their life.

This was Lloyd Pendleton's insistence in Utah, where he headed the state's Homeless Task Force: House people first; offer support second.

From 2006 to 2015, under his Housing First program, Utah's chronic homelessness dropped by 91 percent. But the deeper, quieter transformation was even more dramatic: HIV viral loads stabilized, ER visits fell, people lived longer. Stability healed what medicine alone could not. A front door became as therapeutic as any medical prescription.

A home *is* a kind of medicine—one that our system refuses to name.

I think about this often on days like today. I find myself wondering about my patients' lives before they came to the shelter. Were they cold? Scared? How did they get here? I don't think I could be as brave or strong as they've been. I couldn't sleep in a cold car or go days being hungry. I don't know that I could endure what they've endured—and yet they receive little sympathy from our society, and even less help.

Beneath all of this lie quieter, harder questions: *Are we doing enough? Could I do more?*

The honest answer is yes. I *could* do more, and there are people who already are. In what's known as street medicine, medical students, residents and physicians across the country are walking the streets, crawling under bridges, trudging through homeless encampments to meet the most vulnerable where they are.

Dr. Jim Withers, one of street medicine's founders, said it simply: "Going to where people need you the most is still a radical idea in health care."

It shouldn't be radical, I tell myself. *It should be expected.*

I have walked these encampments in the cold of winter. The eerily muted city sounds are broken by an occasional cough erupting from a tent or the low crackle of a pallet-wood campfire cooking a meal. I felt shaken by my own discomfort—not just my fear of the unknown, but the condemnation I felt toward the people living here, and my shame at judging them for situations I knew nothing about.

I was shaken, too, by the disdain they felt for *me.* To them, I was no different than the people who'd thrown them out of ERs and stores—no different than the police who force them out of the few places they can shelter. I wasn't someone they could trust, because I represented a system that separates medicine from basic human needs.

Street medicine, Housing First, Geiger's "food as medicine" rebellion—they

all share a single truth: People heal best when their basic needs are met, when dignity is restored, when care reaches out to them rather than demanding that they reach for it.

As our van winds down for the day, I sweep the small space, pack up the supplies and look out at the shelter. It’s afternoon, and the school bus is back. Just like anywhere else, the kids are greeted by doting parents, and together they retreat into their temporary refuge.

Inside this place, my colleagues and I see families trying, hoping, holding onto the possibility of stability. Outside of this place, we see the systems—health care, housing, social support—that remain too fragmented to meet the enormity of their needs.

But still, we come. We keep showing up. And that matters.

Because health doesn’t begin in the exam room.

It begins in a bed you don’t lose, a meal you can count on, and someone who shows up where you are.