

Medical Education Coverage of Homelessness Within Canadian Curricula

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Type of Paper: Position Paper

Approved Date: April 13, 2019

Revised Date: April 13, 2019



CFMS
Canadian Federation
of Medical Students

FEMC
Fédération des étudiants et des
étudiantes en médecine du Canada



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Date March 22, 2019
POSITION PAPER

Homelessness in Canadian affects over 235, 000 Canadians per year, with 35, 000 individuals experiencing homelessness per night as estimated by the 2016 State of Homelessness in Canada report. As future physicians, we are likely to see individuals who fit within the spectrum of homelessness, a population that faces stigma from healthcare providers, social and economic disparities, marginalization, and are at an increased risk of medical comorbidities. The Canadian Task Force for Homelessness Advocacy, a group made up of over thirty-five medical students spanning across eleven medical schools in Canada, conducted a robust literature review that focused on medical education and its teaching of homelessness and health, and the implications of medical education on health care quality and policy. Additionally, the task force created a student survey with six open-ended questions focusing on curricular approach to caring for those experiencing homelessness within the pre-clerkship and clerkship context. This survey found that 54% medical students saw opportunity for improvement in their curricula, in the form of more lectures, increased interaction with individuals with lived experience, and community resources. Furthermore, students reported missing key information on health and homelessness, beyond the social determinants of precarious housing which they feel should be more thoroughly addressed in medical education. Given these findings, this position paper highlights recommended changes medical curriculums can consider implementing to better serve this important population.

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Introduction:

Homelessness in Canada affects approximately 235,000 Canadians per year, with over 35,000 individuals experiencing homelessness on any given night, as estimated by the 2016 State of Homelessness in Canada report.(1) These statistics are based on the number of people accessing emergency homelessness shelters, violence against women centres, temporary institutional accommodation, and those who are unsheltered. Importantly, there are Canadians not captured by this data who experience hidden homelessness: a term given to individuals without permanent housing but who are temporarily housed by friends or family (Canadian Observatory on Homelessness definition). Although there is no reliable data on 'hidden homelessness' in Canada, the 2013 State of Homelessness in Canada estimates approximately 50,000 individuals experience hidden homelessness on a given night, and additional Canadian research estimates that for every one person experiencing overt homelessness, there are 3.5 individuals experiencing hidden homelessness.(2)

As part of the social determinants of health (SDOH), homelessness strongly impacts the health of Canadians. The WHO defines SDOH as "the conditions in which people are born, grow, live, and age".(3) These include the economic, social, and political systems that influence differences in the health status of individuals, such as access to education, sufficient work, and adequate housing; they directly shape our health and our access to social services including healthcare.

Furthermore, older adults are the fastest growing demographic amongst individuals who are homeless in Canada, as the effects of an aging population are compounded with rising housing costs and insecure employment.(4) This population is heavily burdened with medical comorbidities, including cancer and cardiovascular disease, which together represent the leading cause of death amongst individuals experiencing homelessness.(5) Despite a clear need for primary care services, these individuals often suffer from a lack of access as a result of their social, economic, and historic marginalization.(6, 7)

As future physicians, we are likely to see individuals who are on the spectrum of homelessness in our practice. Encompassing individuals experiencing chronic homelessness, transient homelessness, or hidden homelessness, each population has their own unique needs. However, currently there is no standardized incorporation of homelessness within current curricula across the medical schools, despite indication to do so through objectives set by the Licensing Medical Council of Canada (LMCC).(8) In this position paper, we aim to report on the current state of education on homelessness in medical schools across Canada and student perspectives on this important issue. We will conclude with recommendations for the incorporation of homelessness and health education in each Canadian medical school, to meet the objectives set by the LMCC and our moral obligation as future physicians to the communities in which we live and work.

Medical Education:

A broad literature search on homelessness and medical education found that there are a limited number of publications and no consensus on how to integrate this vital issue into Canadian medical curricula.(9, 10) In addition, there is a relative lack of training among healthcare professionals in identifying and addressing needs within this complex population.(9) In the pre-clerkship years, the incorporation of homelessness in medical education is mainly through lecture-based teaching and case-based learning.(9, 11) However, as pointed out by To et al., the health and social needs of individuals experiencing homelessness are often overlooked in the case-based medical curriculum.(9) This leaves students feeling unprepared to account for the role of housing and poverty in their patients' care, and without a practical understanding of how to access community resources.(12, 13)

During clinical years, research studies have demonstrated improved student attitudes, interest, and preparedness towards serving those experiencing homelessness following clinical exposures, such as homeless shelter visits, direct clinical encounters with individuals experiencing homelessness, or student-run free clinics at homeless shelters.(10, 12, 14-19) However, the vast majority of these examples come from the American context.

There is relatively little clinical exposure within Canadian medical training. The majority of exposure to homelessness education is completed through elective experience during clerkship, or through extra-curricular activities for interested participants within the pre-clerkship or clerkship settings.(10) Based on the results of these findings in the literature, it appears that there is a need to incorporate more formal education on homelessness in Canadian medical schools in order to develop nationwide best practices.

Student Perspective:

In order to understand how the topic of homelessness is currently being taught in Canadian medical schools, a survey was created to address the current curricular approach towards homelessness, and was sent out to the 17 Canadian medical schools. Of these 17 schools, responses were received from 11. All students who had completed at least one year of medical school were eligible to complete the survey and were invited to do so through an online Google form featuring 6 open-response questions. A total of 116 survey responses were received and used to analyze approaches to pre-clerkship, clerkship, and overall curricula.

General Curricula Approach towards Homelessness in Schools:

A significant proportion of respondents felt that homelessness was not being adequately taught throughout their medical school education. Specifically, 54% of medical students reported opportunity for improvement in their exposure to themes surrounding homelessness; 20% felt that it was not addressed at all; while 25% felt that it was being minimally taught; and 9% found that it was only being addressed through self-initiated electives or extra-curricular activities (Figure 1). The proportion of students from each school who felt that homelessness was being adequately taught or taught in the context of social determinants of health (SDOH) varied between 25-87%, with 8/11 schools falling between 44-56%.

Further investigation centered on the curricular approach towards homelessness by categorizing the different ways that students felt they had been exposed to the topic of homelessness in medical school. The main categories that emerged were lecture (23%), through SDOH or population health course components (47%), electives or extra-curricular experiences (15%), case-based learning (10%), directly working with homeless populations (7%), not taught (16%), or other (including a student presentation and “professional competencies”, 4%) (see Figure 2).

Students were also asked if they had personal involvement in student groups or advocacy initiatives. Out of the total 116 responses, 38% of students reported involvement, mostly through volunteer experiences prior to or during medical school. Responses included community service learning, volunteering, clinical electives, and research.

According to respondents, the most common teaching medium around homelessness was found to be through education on SDOH or population health. As such, analysis of whether or not most medical schools have a SDOH curriculum was undertaken. SDOH are defined as “the broad range of personal, social, economic, and environmental factors that determine individual and population health” (3), and include income, education, employment, and housing, among others. Encouragingly, 82% of Canadian medical students felt that their school did have a curriculum for SDOH (Figure 3). However, the presence of a SDOH curriculum did not guarantee that homelessness was one of the topics discussed; in fact, 50% of students who reported that their school did have a SDOH curriculum also responded that homelessness was not part of their education. Therefore, our findings suggest that students are missing key information on health and homelessness, beyond the social determinants of precarious housing, which they feel should be more thoroughly addressed in medical education.

Pre-clerkship Curricula Approach towards Homelessness in Schools:

Based on survey responses, student suggestions for improvements in pre-clerkship curricula can be broadly categorized as 1) more lectures on homelessness; 2) partnering with people who have lived experience; and 3) information about community resources. Out of the 116 total responses, 13% of students wished to see more lectures, whether it be by an increased amount (e.g. during lunch time) or by adding additional content to existing presentations, including mention of the intersections of homelessness with LGBTQ+, hidden homelessness, challenges of health services delivery to these populations, and health needs specific to this population. 13% of students suggested inviting individuals with lived experiences to their schools to learn more about their experiences of transitioning from different care sites and homes, and navigating through the social and medical systems.

Students identified a lack of knowledge and confidence around physicians' referral options and the role of social work in managing cases of homelessness. 10% of students directly mentioned the benefits of learning about resources in their communities, including those that provide assistance with housing, employment, and finance. Finally, 43% of students suggested they would like to see other formats of curricula introduced, such as group sessions, community service opportunities, skills sessions, online modules, or speaker series with professionals and community outreach groups.

Clerkship Curricula Approach towards Homelessness in Schools:

Students were asked what they would like to see incorporated into clerkship. 29% of respondents wanted to see opportunities for community outreach and working with vulnerable populations integrated into the clerkship curriculum. Specifically, suggestions included mandatory sub-rotations in inner city health clinics during the family medicine rotation, and working in community clinics that specialize in caring for vulnerable populations as possible integrations of homelessness education into core clerkship rotations. 20% of respondents wanted to see dedicated teaching time devoted to homelessness and appropriate clinical interventions. Notably, rotation-specific teaching during family medicine, CTU, psychiatry, and emergency medicine was mentioned frequently.

Similar to responses for pre-clerkship education, 13% of respondents indicated they would like to see education around accessible resources for vulnerable populations during their clerkship. Additional responses included students who wish to see more obvious elective options, opportunities to learn from patients' lived experiences, more education around current interventions (e.g. 'No Fixed Address' in discharge planning), more education around interprofessional team approaches to homelessness, and opportunities to volunteer with community organizations. While a small number of respondents felt that they had received adequate preparation around homelessness and working with vulnerable populations in pre-clerkship courses, the majority of students wished for increased preparation.

Discussion:

Beyond Medical Education - Attitudes of Health Professionals

Healthcare professional attitudes are largely impacted by the education that they receive towards individuals experiencing homelessness. Doran et al (2014) found that residents within the emergency medicine specialty learned how to care for individuals experiencing homelessness through informal teaching and experience, as opposed to formal curricula. One method of learning mentioned was "stories of misses . . . in which patients who were homeless had bad outcomes." Residents' responses showed increasingly complex emotional response to patients who were homeless, "dominated by feelings of frustration . . . related to feelings of futility in truly helping homeless patients." Residents in this study felt they needed more formalized curricula and support in caring for these vulnerable populations.(11)

Individuals experiencing homelessness have also reported negative interactions with health professionals, including reports of health professionals acting with suspicion, asking questions unpleasantly, and acting “like they know better”.(20) A lack of understanding and empathy contribute to individuals having a high degree of unmet need with regards to their healthcare.(21-27). Relationship barriers and lack of empathy do not allow the healthcare provider and patient to agree to common goals.(24) Unmet needs not only contribute to poor health, but also make individuals less likely to use the healthcare system in the future.(26) Demonstrating cultural sensitivity and empathy has been shown to improve an individual’s satisfaction with their overall health care experience, and their overall engagement with the healthcare system.(28) Key ingredients include “respect for the individual, upholding the person’s dignity, building mutual trust, and showing warmth and care.” (22)

In order to prevent these negative prejudices towards this at-risk population, it is important to implement early training for medical students to ensure that the best possible care is given to those suffering from the burden of homelessness with a caring and empathetic attitude. This is particularly important for primary care providers, because of their long-term support and preventative interventions, which require a therapeutic relationship with patients.

Implications for healthcare

While primary preventative care is an essential part of care for these populations due to their likelihood of serious comorbidities, individuals experiencing homelessness oftentimes still lack a family doctor and/or have unmet health needs.(6,26) Examples include persistent chronic pain and subsequent usage of street drugs due to lack of follow-up by primary care practitioners.(29)

It is well known that access to a family doctor can decrease poor outcomes and health care spending; however, approaches that integrate allied health with other useful resources, such as addiction services and mental health, may better address the needs of this population.(30) One randomised study found that a specialized homelessness care team improved quality of life and reduced street homelessness when compared to a usual care team.(30) Another showed how communications with community-based providers facilitate continuation of care in the community.(13) While quality of care remains an issue among homeless populations, interdisciplinary teams composed of allied health professionals and community-based organisations have been shown to improve outcomes and better address the needs of this population, which is why they should be an important focus of medical education going forward. Regardless, it is clear that more needs to be done to solve the systemic issues faced by this segment of the population.

Implications for public policy

Lack of coverage on the biopsychosocial health of homeless populations also raises the issue of uninformed public health interventions. Silva et al. (2013) note that “perhaps the reason that there exist so few pandemic plans that adequately address homelessness is that so few people who wrote pandemic plans have experienced homelessness; the recommendations supplied may not accord with the lived reality of persons who are homeless”. (31) In brief, without appropriate education on issues regarding the health of this population, public policies and strategies will continue to provide a lack of adequate services that may render any advocacy efforts ineffective. For example, while physicians may be able to secure housing for these patients, most sheltered individuals continue to face hidden yet persistent economic and psychosocial barriers including poverty, isolation and a feeling of “outsiderness”. (32) The need for broader services is only intensified for individuals facing multiple other forms of stigma and discrimination, such as HIV positive individuals, Indigenous peoples and youth.(33,34) A lack of knowledge and skills to address these factors contribute to individuals being stuck in a “perpetual state of poverty” and inability to achieve an improved quality of life.(32)

Conversely, interventions that work with and prioritize the perspectives of those with lived experience can have the most positive impact. For example, Housing First policies are associated with decreased barriers to exiting homelessness, and factors that improve adjustment to exiting homelessness such as a sense of security and developing meaningful activities.⁽³⁵⁾ Another example is the Community of Support in Northern Canada - where individuals experiencing homelessness share their experience and skills within an interprofessional team in an effort to develop inclusive solutions.⁽³⁶⁾ These successful bottom-up public health interventions demonstrate the need for physician advocates attuned to the unique circumstances of their patients. It further drives home the importance of physician education by way of community service, speaker series, or focus groups that are guided by people with lived experience.

Limitations & Future Research

Future research should go beyond measuring the level of involvement for medical students, towards observing residents or even physicians. Additionally, these recommendations and findings should be presented to community organizations with relevant expertise, and those with lived experiences, to receive their input.

Before proceeding with our recommendations, it is worth noting a few limitations of our research. Firstly, the review, while comprehensive, was not systematic and therefore some literature may have been omitted. Secondly, while the survey was distributed to all 17 medical schools in Canada, responses were received from only 11. Given responses were voluntary, it is more likely that students who have an interest in homelessness and health would have filled out the survey, than those who are not interested. This may have biased our survey results. Despite this, the high number of thoughtful responses does indicate that there is interest in this topic by a large number of medical students. Finally, while it may not be feasible for individual schools to adopt all these recommendations, any adaptations of medical curricula to encourage a broader perspective on the topic of homelessness will likely benefit this population.

Our Recommendations:

While healthcare is characterized as a universal right, there are still difficulties in accessing healthcare for at-risk unsheltered or emergency-sheltered populations. While the length of time being homeless in itself has been shown to reduce the odds of having a primary-care physician, homelessness can also present other barriers to primary or alternate levels of care such as differing priorities in day-to-day life, psychological distress, and medical comorbidities.⁽⁶⁾ A continuum of care and access to physicians is important to develop and see-through treatment plans, adhere to medications, and treat complicated illness. This starts with integrating these themes within medical education and teaching, to foster a generation of health practitioners who will not only serve as strong care providers, but also prove to be strong patient advocates.

Through inclusion of medical student sentiment and robust literature review, we have found that there appears to be a gap in addressing care of populations at risk of becoming, or currently experiencing, homelessness or temporary housing, despite having two LMCC objectives specifically dedicated to caring for this population with unique healthcare needs.

The LMCC recognizes the following two objectives related to the care of homeless populations to be critical for the training of physicians who can address the current disparity in health equity:

1. Identify the challenges of providing preventative and curative services to homeless persons; and
2. Discuss the major health risks associated with homelessness as well as the associated conditions such as mental illness.

Despite these objectives, evidence shows that medical trainees lack appropriate skills to effectively manage the health of this growing vulnerable population. Moreover, more than 50% of Canadian medical students surveyed felt that homelessness and health was not properly addressed at their school. It appears clear that adjustments need to be made in Canadian medical school curricula to address this gap in knowledge.

This position paper therefore suggests medical schools consider including the following recommendations:

1. Homelessness and health should be further developed in the Canadian medical curricula by means of core lectures, case-based learning, or service-based learning available to all pre-clerkship and clerkship students. These should be separate from, and in addition to, broad SDOH lectures on income insecurity or precarious housing.
2. Students should have the opportunity to work with people with lived homeless experience in the community throughout the course of their clinical training. Opportunities for clinical experiences in the inner city should be made available, along with preceptors being willing to take on students.
3. Medical education on homelessness and health should include input from stakeholders working with populations with lived homeless experience, and individuals with lived experiences. It is recommended that a heavy focus should be on community and allied health collaboration in an effort to create engaged, informed, and sensitive future physician-advocates.
4. Medical students should be taught important resources in accordance to formalized lectures and/or case based learning. This should transition into training on making appropriate referrals, and organizing discharge and follow-up for individuals who are experiencing homelessness.
5. Students should be given opportunities to learn more about the intersections between developing health-related policy or advocacy initiatives, in parallel to their medical training.
6. Learning objectives should follow the LMCC objectives and also include skills training or advocacy efforts to help students address the gaps in the care of people with lived homeless experience.

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Appendix:

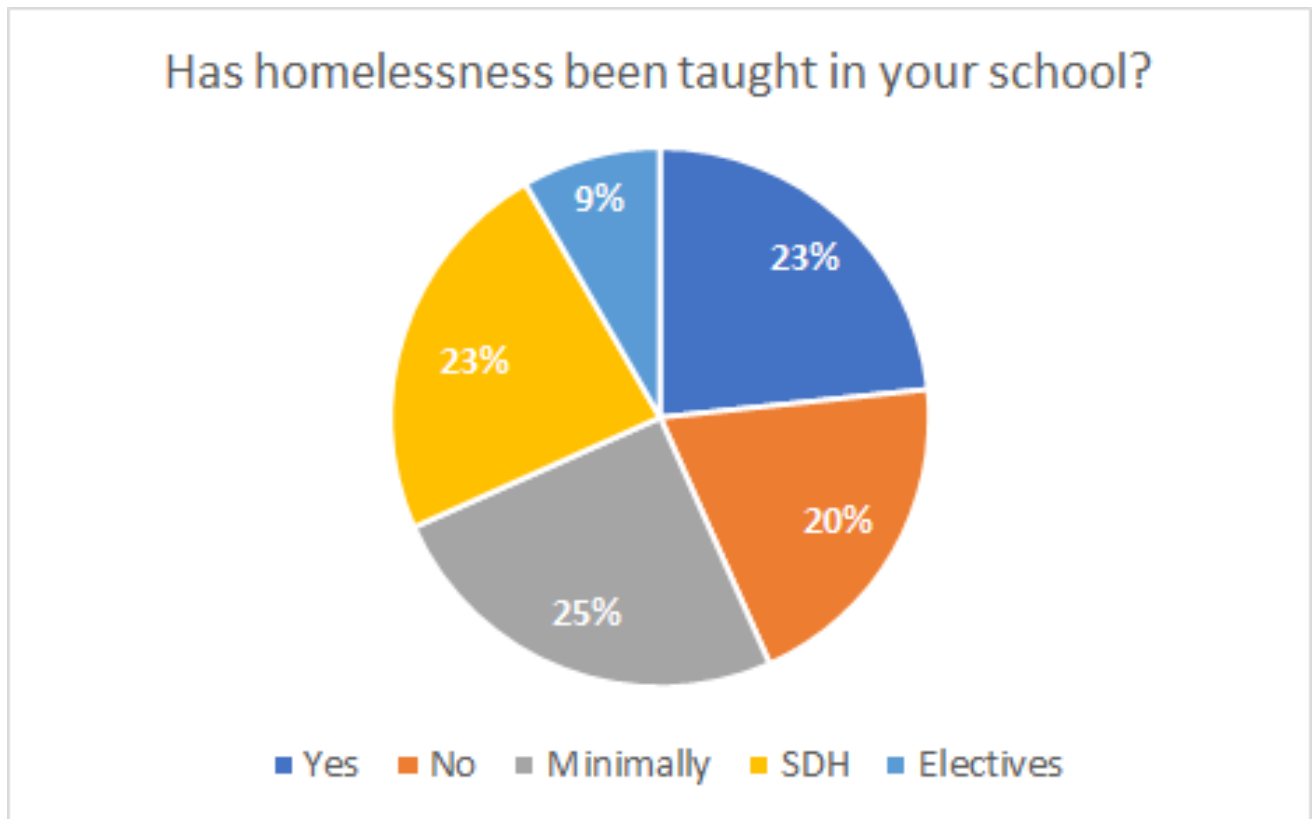


Figure 1: Has homelessness been taught in medical school? 116 students responded and answers were categorized into “Yes, homelessness is being taught”, “No, homelessness is not being taught”, “Homelessness is being taught minimally”, “Homelessness is being taught in the context of social determinants of health (SDH)”, or “Homelessness is only being taught in electives or extra-curricular experiences”.

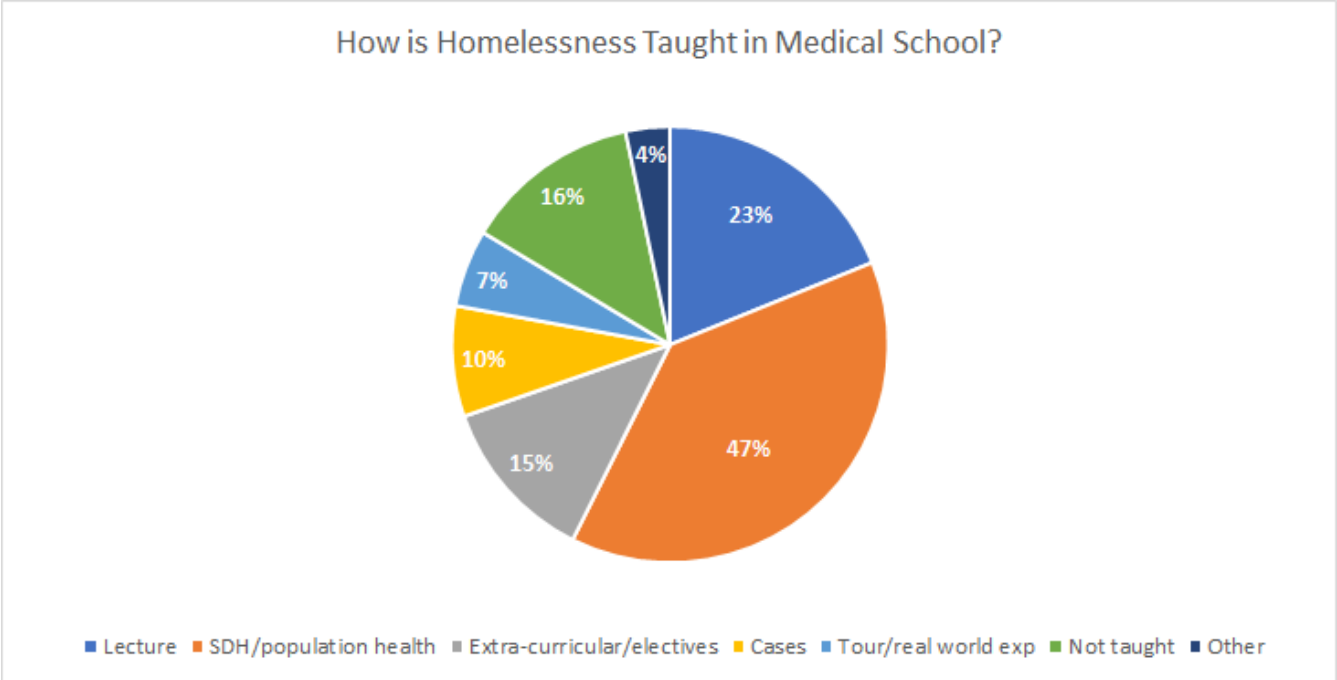


Figure 2: How is Homelessness Taught in Medical School? 103 students responded and answers were grouped into the above categories.

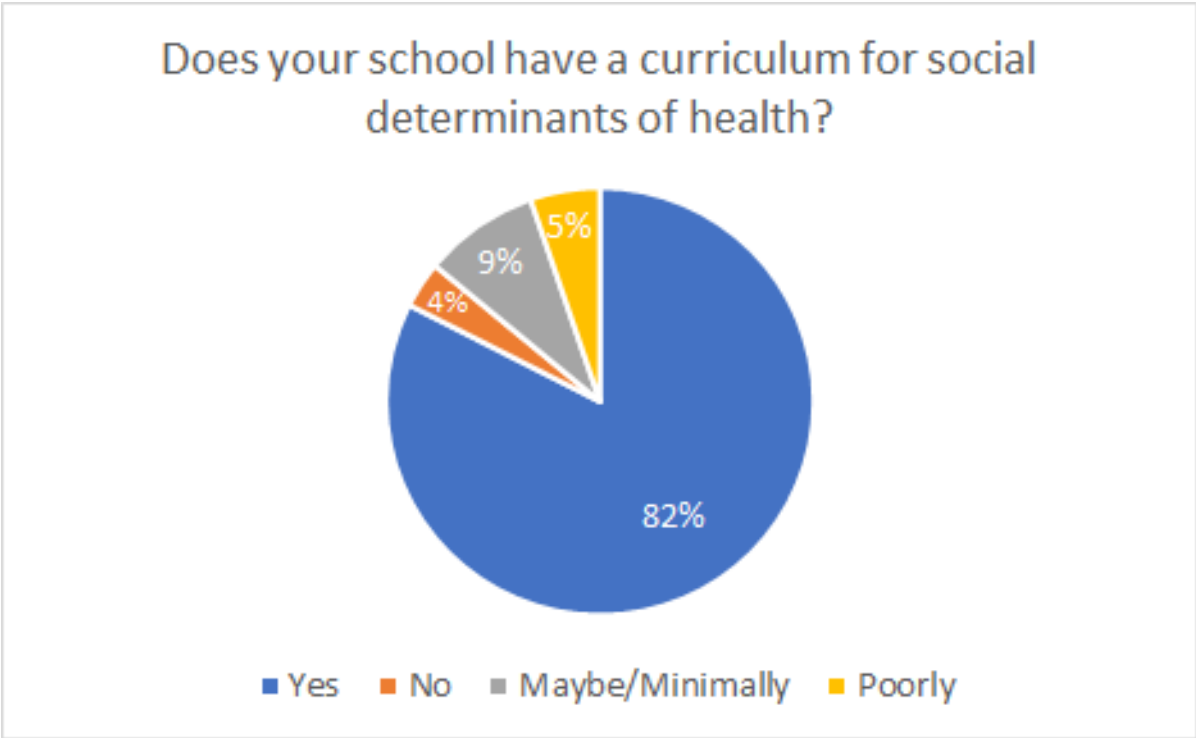


Figure 3: Does your school have a curriculum for social determinants of health? 116 students responded and answers were categorized into “Yes”, “No”, “Maybe or minimally”, and “the curriculum does exist, but it is taught poorly”.