

Helping the Unhoused: Addressing Inadequacies in Ontario's Medical School Curricula

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INTRODUCTION

Across all Canadian cities, a silent pandemic looms, revealing a staggering reality in which individuals are left to the streets. In 2016, there were over 235,000 Canadians without stable housing and 25,000 Canadians facing the harsh realities of lacking housing on any given night (1). While no equivalent statistics have been published since the COVID-19 pandemic began in 2020, the financial strains caused by lack of steady employment have only magnified these numbers (2). Homelessness is a unique problem in our healthcare system because it is both a cause and consequence of poor health outcomes. Individuals with health conditions that preclude them the ability to work and/or require high costs of treatment may not be able to afford housing while managing their wellbeing (1). There is no doubt that homelessness is an isolating, dangerous, and painful experience that, as a result, leads to a disproportionate amount of mental health challenges and/or substance use and addiction in this population (1). Many studies have shown that those who experience homelessness are then at greater risk of poor health outcomes, including “seizures, musculoskeletal disorders, respiratory infections, and illnesses such as tuberculosis and HIV” (1-4). Addiction, and homelessness by-proxy, can be lethal conditions. While the opioid-related overdose deaths in Ontario increased two-fold from 2017 to 2021, it rose by nearly four-fold among the unhoused community. Even more detrimental is the fact that compared to individuals with stable housing who died of overdose, those without stable housing with similar deaths were younger, more often lived in major urban centers, and were more likely to have sought out care for their mental health or substance use disorders (5).

At the most basic level, 29% of homeless individuals in Toronto have no dependable source of healthcare (6). Furthermore, this statistic does not account for the barriers to accessing healthcare that is patient-centered and focused on harm reduction. Primary care should serve as a major care access point for all Canadians, but many patients without stable housing struggle to find a family physician due to a lack of trust or not having a health card (6, 7). Moreover, family physicians may deny them care if there are additional complexities to their health (i.e. chronic illnesses, substance use disorders, etc.) (6). Without access to primary care, many unhoused individuals may turn to local emergency departments where they risk negative experiences due to discrimination and imposition of biases by healthcare providers (6) and current harmful protocols for hospitalizing those with psychiatric conditions, such as “isolation, mandatory assessment, and the imposition of curfews on hospital passes” (7), at times even if they are not struggling with psychiatric symptoms. Such negative encounters with Canada's healthcare system perpetuates distrust in more than just the affected patient, as they may share their experiences of lack of empathy and alienation with friends and acquaintances (7).

Despite the best efforts of many physicians, implicit biases affect the healthcare patients receive (8). This holds true in the context of healthcare providers treating patients experiencing homelessness. For instance, many patients experiencing homelessness visiting the emergency department felt prejudged as drug seekers by their clinicians (9). Additionally, patients experiencing homelessness felt that when their clinician became aware of their housing status, the quality of care they received deteriorated, or they were denied care all together for conditions like mental illness, chronic pain, and addictions (9). The attitudes of clinicians, intentional or unintentional, are thus negatively impacting the care their patients experiencing homelessness are experiencing. The downstream effects of implicit biases amongst healthcare workers extend beyond patient encounters. Healthcare professionals may be quick to deem a patient without stable housing as “lost to follow up” or “resistant to advice” when they do not return for follow-up appointments or take prescriptions as advised, but one must be cognizant of the financial implications of accessing transport, prescription medications, or out-patient services (7). There is a clear need for improved transitioning between providers and physician-patient communication of community support (7).

Unfortunately, these attitudes and implicit biases may extend to medical students as well. A study conducted in the United Kingdom showed that medical students may hold more negative attitudes towards unhoused people at the end of their undergraduate course than they do at the beginning of it (10). Given that a great portion of medical education involves medical trainees learning by observing and modeling their preceptors, negative biases may continue to propagate from preceptor to student (11) [11]. Seeing as individuals experiencing homelessness are a vulnerable population that health care providers interact with regularly throughout their career, concentrated efforts must be put in place to increase exposure to issues faced by homeless individuals so that they may be able to support them in a positive, empathetic, and trauma-informed manner.

As such, it is imperative that medical education actively mitigates the negative misconceptions regarding homelessness in healthcare in order to improve care and patient outcomes in the future. Upon review of the Medical Council of Canada (MCC) objectives, only objective 127, “providing anti-oppressive care,” addresses homelessness; however, it is not the primary focus of the objective. Within objective 127, both the “rationale” and “key objectives” fail to directly address homelessness. It is only within enabling objective 1, “gain understanding” that homelessness is specifically mentioned. Homelessness is also not specifically mentioned in enabling objectives 2-6 (“provide support,” “practice,” “communicate,” “collaborate,” and “advocate”) despite these being fundamental to understanding how to provide individuals experiencing homelessness with the care they not only need, but deserve.

Despite the limited objectives set by the MCC, Homelessness is a unique problem in our healthcare system because it is both a cause and consequence of poor health outcomes. From the limited research that exists in the field, it appears as though a majority of this integration is done during clerkship. One study conducted on 145 American medical students showed that they would be more comfortable with providing healthcare to homeless individuals once they have completed their psychiatry clerkship rotation as they expect to see more homeless patients, given the high rates of mental illness in the vulnerable population (12). However, people experiencing homelessness also exhibit various comorbid conditions including hypertension, alcohol use disorder, chronic kidney disease, asthma, chronic obstructive pulmonary disorder, hyperlipidemia, diabetes, etc., not solely mental health conditions (13). Therefore, it is extremely important that students are exposed to teaching about homeless individuals in all their specialties, not just in the context of psychiatry rotation or residency.

Recognizing this issue, some medical schools and students have implemented programs that can help increase awareness and exposure to homelessness in other specialties, especially in clerkship. The University of California, San Francisco implemented a mandatory two-week clinical electives for students in clerkship that involved lecture series, clinical work, and site visits to homeless shelters and adjoining clinics. On evaluation, the students strongly agreed that the experience taught them innovative ways to provide care to patients experiencing homelessness (14). When this program was later implemented for internal medicine residents, they found that the Attitudes Towards Homeless Individuals (ATHI) scores had increased significantly and had increased their interest in volunteering (15). More recently, a compulsory clinical experience in homeless health was integrated into the family medicine clerkship curriculum for third-year medical students at the University of Toronto. While the Health Professionals’ Attitudes Towards

Homeless Inventory (HPATHI) scores did not change pre- and post- rotation significantly, students indicated that the programme was a positive learning experience regarding physician advocacy, understanding the complexity of homelessness issues, and addressing gaps in their curriculum (16). While some North American medical schools have begun to implement programs aimed at preparing medical students to manage homelessness in clerkship years with some success, there is no standard integration of education about homelessness in the pre-clerkship curriculum of Ontario medical schools (11, 14-17). One attempt at collecting information about homelessness in the curricula of multiple Canadian medical schools was undertaken by the Canadian Federation of Medical Students' (CFMS) task force on homelessness in 2019. Survey results from 116 students from 11 participating schools found that 29% of the students, mainly those in their clerkships, expressed wishes to work directly with this population, with some suggesting mandatory inner-city rotations as a possible option (17).

Although programs like this have existed for medical students in their clinical years, there is still progress to be made to promote preclerkship medical education for issues related to homelessness. Currently, this integration is mainly done through lecture-based content, case-based learning, and sometimes service learning placements. One study examined an Ontarian medical school's case-based learning (CBL) and found that homelessness was only mentioned in five out of 196 CBL cases (2.6%). In the cases where homelessness was mentioned, characters' social contexts were ignored and negative stereotypes about this vulnerable community were reinforced (18). Another study conducted at the University of Toronto sought to integrate homelessness in the curriculum through a Pen-pals' project. The researchers explored pre-clerkship medical students' experience in a four-week letter exchange with individuals experiencing homelessness and found that this project endorsed improved communication, empathy, and advocacy skills. Unsurprisingly, all students believed that the current medical curriculum was lacking in the field of homelessness (19). Similarly, the CFMS survey found that the majority of students felt that homelessness was not adequately being taught, especially in the pre-clerkship portion of their education, with many being exposed to this population only through extracurriculars, volunteering, and electives (17).

PRINCIPLES

We put forward the following principles to guide our below recommendations for implementing standardized training on the health of Canada's unhoused population into medical education:

1. **Duty to Medical Students:** Ensure undergraduate medical education incorporates high quality, current evidence-based practices that reflect the principles of social justice and patient safety irrespective of medical school attended, student gender identity, ethnicity, socioeconomic status, or religious beliefs.
2. **Duty to Patients:** All seven of the prerequisites for health, as outlined in the Ottawa Charter for Health Promotion should be accessible to all patients. In order for the accessibility and universality of healthcare in Ontario to improve, standardized training to deconstruct and reshape patient-centered approaches to marginalized individuals must be accessible to Ontarian medical students.
3. **Duty to Health System:** Given the prevalence of homelessness, the internal barriers and biases amongst physicians that can lead to discriminatory care of marginalized populations, and the complex web of intersectionalities that can further contribute to poor health, there is an urgent need for future practitioners to have opportunities to reflect on current biases and preconceptions, learn how to dismantle biases, and build a toolkit to recognize future biases.

RECOMMENDATIONS

1. **Evaluate the current state of homelessness curricula from Ontario's medical schools to identify strengths, weaknesses, and opportunities for curriculum standardization.**
 - Rationale:
 - To ensure that there is an accurate and updated record of how homelessness is taught in Canadian medical schools currently, the Schulich Homeless Advocacy Club must

collect data from multiple Canadian schools, starting with Ontario. In the past 5 years since the CFMS task force's appraisals, rates of individuals experiencing homelessness and vulnerable housing have skyrocketed with the COVID-19 pandemic (4) and many Canadian medical schools have updated their curricula, necessitating a thorough re-examination.

- Implementation Strategy:
 - Over the next two months, Schulich Homeless Advocacy Club will come up with a simple online anonymous survey which will allow for collection of student perspectives on the strengths, weaknesses, and suggestions relating to teaching on homelessness in their curricula. The target of this survey will be medical students enrolled in an Ontario medical school and have completed at least 1 year of study.
 - Once the survey is ready for distribution, Schulich Homeless Advocacy Club will pilot this within our own school at the Schulich School of Medicine and Dentistry to highlight key areas of concern and troubleshoot any technical difficulties.
 - Schulich Homeless Advocacy Club then aims to connect with student leaders in each of the six Ontario medical schools, and send them the survey to disseminate amongst their classmates. The survey will be open for a few months, with follow-up with the student leaders in the meantime, keeping in mind the busy schedules of our target participants.
 - After the timeline has elapsed, the results will be collated to identify strengths, opportunities for improvement, and recurrent themes. This will allow us and other interested student groups to brainstorm initiatives, workshops, and advocacy work on issues that matter most to students.
- Barriers:
 - The main barrier we face is connecting and establishing a strong network of student leaders in the various schools. We hope the OMSA VP Externals from each medical school will be able to assist us with this by taking on this role or finding delegates on their behalf. After making contact with these students, we may be able to establish points of contact at each school for any follow ups and reminders.
 - We anticipate that survey response rates may not be as high as targeted. However, we will aim to increase the rates by ensuring that the survey is short to complete and students understand the anonymous nature of the data collection. We could also brainstorm incentivizing survey responses with the various student leaders through raffles, gift cards, etc. If we choose to do this, we would require some funding, which has potential to be acquired through student-led initiatives and grants.

2. With representatives from the OMSA VP External, VP EDI, and VP Education committees to act as provincial liaisons, implement province-wide curriculum changes geared toward addressing curriculum shortcomings in the context of homelessness.

- Rationale:
 - To ensure that there are individuals and resources committed to making changes based on the gaps identified within curriculums across Ontario, a committee or working group within OMSA is very valuable. This would ensure that there is continuous monitoring of curriculum changes being made, resources available to ensure changes are being implemented, and long term follow through of proposed changes.
- Implementation strategy:
 - Over the next 3 months, Schulich Homeless Advocacy Club will develop a set of objectives and goals for the working group centered around promoting changes within medical school curriculums to ensure students are adequately educated on caring for individuals experiencing homelessness. Our goal would be to have a diverse group of clinicians involved in caring for this patient population, community members, individuals who have experienced homelessness, as well as current medical students on this committee to ensure needs are being properly addressed.
 - Upon the establishment of the objectives and goals of the committee, position descriptions/terms of reference will be developed with the help of OMSA. The terms of reference will outline the goals, expectations, and requirements of the roles, in line with

those of other OMSA committees. There will be 1-2 committee chair positions available, and 2-3 committee member positions. Hiring for the committee chair and committee member positions will then correspond with traditional OMSA timelines. We hope that through the OMSA network, we will be able to find students at medical schools across Ontario that are passionate about improving homeless advocacy education.

- Once the committee chairs and members have been hired, terms of reference, goals, and objectives will be reviewed. The committee will then work with curriculum developers at medical schools across Ontario to address the existing curriculum gaps, and propose possible changes into UME curriculums as appropriate to promote improved teaching on caring for individuals experiencing homelessness. By establishing this committee within the OMSA, we will provide students with the platform to address this education gap and promote positive change at Ontario medical schools. The Schulich Homeless Advocacy Club aims for this committee to be hired by November 2024 and for a working curriculum to be created by February 2025.
- Implementation success is defined as having a committee that meets the following criteria:
 - Includes a diverse set of individuals and perspectives from all six Ontarian medical schools, as defined above.
 - Creates a working curriculum aimed at addressing gaps in knowledge about healthcare for those experiencing homelessness, as identified by the evaluation outlined in recommendation #1.
 - Working curriculum is revised and approved by healthcare workers who work with those experiencing homelessness, those with lived experiences of homelessness, curriculum leads at Ontarian medical schools, and the OMSA VP Education.
- Barriers:
 - A foreseeable barrier is the timely initial development of this committee/working group. Developing the working group will require writing position descriptions/terms of reference, as well as undergoing a formal hiring process, including reviewing applicants and selecting qualified medical students to fill the roles. Given the proximity of the start of the 2024/2025 academic year, this may be a challenge. If we are given approval, we will aim to provide terms of reference that align with the OMSA hiring cycles.
 - Another foreseeable barrier is connecting with the curriculum developers at each medical school, and helping them appreciate that the education provided to medical trainees regarding individuals experiencing homelessness is something that must be revised. We hope to formulate responses to frequently asked questions, and propose recommendations tailored to each school that are feasible and easy to incorporate into existing curriculums.
- 3. **Create a standardized deliverable (such as a workshop) supported and promoted by the OMSA in 2024/2025 that addresses the unique healthcare needs of Ontario's unhoused population, dismantles medical student biases related to this group, and helps students create a toolkit to develop a patient-centered approach to care that focuses on harm reduction.**
 - To ensure standardized training about deconstructing biases and reshaping patient-centered approaches to marginalized individuals is available to all Ontarian medical students, we envision this workshop being designed and led in collaboration between the OMSA education portfolio and ourselves at each of the six Ontarian medical schools throughout the 2024/2025 academic year. While the onus could be placed on each medical school's curriculum team to ensure this workshop is implemented, placing the responsibility upon OMSA ensures standardized education across all institutions.
 - Implementation Strategy:
 - In order to measure the success of this workshop, all medical students attending the workshop will be asked to complete the ATHI and HPATHI questionnaires used by previous studies (12, 13) to assess student attitudes towards those who are unhoused before and

after attending the workshop. As these questionnaires would not provide any insight of the learning value of the workshop, medical students will be asked for their feedback regarding the workshop's ability to address gaps in their curriculum, their learning experience, and their perspectives on whether their knowledge of the homelessness crisis has improved via a qualtrics form after the workshop has finished.

- A foreseeable barrier to implementing this workshop is the cost of time and money for workshop facilitators to attend each of the Ontarian medical schools. If there is no funding available from OMSA to support their travel or if time is of concern, then this workshop could be facilitated via zoom at a single time for all Ontarian medical schools and funding for speaker and attendee gifts could be obtained via a CFMS SIG grant.
- An additional foreseeable barrier is coordinating times to implement this workshop with each of the six Ontarian medical schools. Unfortunately, this barrier can only be overcome with patience and a continued line of communication to organize the workshops.
- If the implementation of this workshop cannot be made mandatory to all pre-clerks in Ontario, then an alternative strategy for implementation could include offering this workshop as an optional session for pre-clerks to attend.
- OMSA can support the implementation of this recommendation by assigning part of their education portfolio to aid in the design of this workshop, connecting with pre-clerkship curriculum leads at each of the six Ontarian medical schools to schedule these workshops for the 2024/2025 academic year, promoting this workshop via social media, assigning delegates and/or providing funding for workshop facilitators to attend each medical school, aiding in the distribution of ATHI, HPATHI, and qualtrics questionnaires, and formally endorsing this initiative as a key step towards improving access and quality of healthcare for unhoused individuals in Ontario.

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