

The right to accessible healthcare: Bringing palliative services to Toronto's homeless and vulnerably housed population

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abstract

In comparison with the general Canadian population, homeless persons and the vulnerably housed face significantly shorter lifespans and experience higher rates of chronic disease, mental illness and polysubstance abuse. Despite their high mortality and morbidity rates, this vulnerable and marginalized population continues to have difficulty accessing essential services such as palliation and end-of-life care. More needs to be accomplished in this area, as dying with dignity is a right that all Canadians should share.

I received the call on a sunny street corner in Vancouver. A voice on the other end of the phone introduced himself as Dr. Naheed Dosani, a palliative medicine doctor from the City of Toronto. I recalled the name; it belonged to the preceptor of my upcoming elective in palliative medicine. Dr. Dosani's next few sentences were unexpected. He asked me what I knew about palliative medicine, what I knew about Toronto's homeless and finally what I knew about the PEACH program. Embarrassingly, I knew very little on the subject of the last question; to me, PEACH was a delicious fruit. As I struggled to answer these impromptu questions, my eyes gazed towards a dishevelled man sleeping against the wall of a nearby coffee shop—oddly, only seconds prior, this man was just part of the scenery. Luckily, Dr. Dosani did not question me further; instead, he informed me that I was in for a "different" experience. He certainly was not wrong. I left on a flight to Toronto the next day not knowing that the next two weeks would expose me to the realities of a marginalized homeless population and challenge my perceptions of palliative healthcare in Canada.

PEACH, as it turns out, stands for Palliative Education and Care for the Homeless. Launched in July 2014, PEACH is a new initiative headed by Dr. Dosani, a young palliative medicine doctor from Toronto, and an interdisciplinary team of

nurses and social support workers. As a mobile support and consultation service for the homeless and vulnerably housed in the City of Toronto, PEACH serves a unique population that is more likely to experience higher rates of cancer, heart disease, infectious disease, psychiatric illness and substance abuse compared to the general population.¹ Furthermore, I was shocked to learn that homeless persons have a mean age at death reported to be between 34-47 years—considerably lower than the 81 years of age that Canadians can, on average, statistically hope to attain.² Despite the significant morbidity and mortality rates seen in this population, the homeless and the vulnerably housed continue to face barriers to accessing healthcare services.¹ Reports indicate that half of Toronto's homeless do not have access to a primary care physician, and that many face end-of-life without palliative care specialists.³ This is where the PEACH program hopes to make a meaningful contribution. Canadian palliative care services were traditionally designed to serve the mainstream population, rather than marginalized populations such as the homeless and the vulnerably housed.³ As a pilot program, PEACH hopes to test the effectiveness of bringing palliative services to Toronto's streets and shelters.

There are, however, challenges. These include, but are not limited to, a lack of

resources, funding, and time dedicated to supporting a transient population that has traditionally been difficult to approach. Conversely, the strength of the PEACH program lies in its ability to meet its clientele where they are. This is

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unique, as it helps the physician better individualize care and helps the patient avoid the complexities of a healthcare system that is not designed to serve their needs. Time will be the real test for the practicality and effectiveness of the PEACH program. The program is actively expanding and greater attention has been drawn to its efforts not only to support but also to educate Toronto's mainstream palliative services on effective practice for the homeless and vulnerably housed.

As one can imagine, this was a lot to take in. After my months of inpatient electives focussed on hospital care, visiting homeless persons on the streets and in shelters to provide palliative services seemed a bizarre concept. Additionally, in stark contrast to our work with the homeless, my preceptor and I spent days providing palliative services in the more traditional and mainstream

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healthcare setting found at Brampton Civic Hospital. I could not have asked for a more reflective experience in medicine. One day we would be doing a consultation in a downtown Tim Hortons for a forty-year-old male withering away from polysubstance abuse and untreated HIV, while the next day we would see a ninety-year-old grandmother in her large, immaculate home in suburban Toronto, surrounded by loving family. The contrast was striking, and the stories moving. I can recall the agony and despair in the eyes of a loving husband whose wife lay dying in a clean hospital bed with all the comforts modern medicine can provide. Conversely, I can recall the look of suffering in a gentleman with end-stage colon cancer who I met in a downtown Toronto shelter. The man was living in an unhygienic environment, without the supports and love that I had previously associated with end-of-life care. Moreover, this gentleman was not connected to the basic community home care services (e.g. nursing, personal support worker visits or medical equipment) that would help him to pass with dignity and comfort. In reflecting on the final stages of these two patients' lives, I couldn't help but wonder: why the stark contrast in care?

It is estimated that 30,000 people in Canada are homeless on any given night.³ We know from research that homeless persons and those vulnerably housed have increased morbidity and significantly decreased lifespans when compared to the general population.^{1,2} Would it not make sense, then, that this particular population be given more opportunities to access essential services such as palliation and end-of-life care? The reality is that such opportunities, where they do exist, are in short supply. The PEACH program is in its infancy, with one palliative medicine specialist working just one day a week to provide services in

an area with an overwhelming need. Why, as a society, do we fall short in providing essential services to a population with such great need? The truth is that homeless persons and those vulnerably housed are marginalized by our healthcare system—whether it be due to a lack of social support, financial means, or purely stigma and discrimination. Services such as palliation are simply not offered to this population or they are assumed to be unimportant. Yet, it took me two weeks of visiting homeless shelters, hearing the stories of the terminally ill and witnessing the conditions in which the homeless die in Canada to recognize that there is a major problem here, and more must be done to address it. The 'E' in PEACH stands for education, and although the focus is patient-centered care, the larger message here is that palliation and end-of-life care is not only a right for those with houses and social supports, but a right that all Canadians should be able to access.

disclosures

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