Transcript
Episode 04 – Not-So-Universal Healthcare: Caring for the Uncared-For, with Doret Cheng

Intro

[intro music plays]

Welcome to Changing Lenses! I'm on a personal journey to explore how we can make our world more inclusive and compassionate, and our lives more fulfilling and sustainable. Along the way, I'm meeting some amazing Canadians doing amazing things. By listening to their stories and experiences, I hope we will change our lens to see from a more inclusive perspective, and be inspired to build a better world. I'm your host, Rosie Yeung, and I invite you to join me as we change our lenses together. Because changing our lens, changes what we see. And when we see differently, we can live differently.

[intro music ends]

Welcome and Introduction

Rosie: Hello! I'm glad you joined us for this episode of Changing Lenses. Today, we'll be talking to Doret Cheng, a pharmacist who has worked in healthcare systems for over 20 years. Doret has years of experience with patient care in various settings, such as community pharmacies, Canadian hospitals, and global healthcare as far away as Uganda.

Doret is of Chinese ethnicity, born in Ghana, immigrated to Edmonton, Canada as a child, and now lives in Toronto, where she currently practices at St. Mike's Hospital, Academic Family Health Team. And she's an Adjunct Lecturer at the University of Toronto, teaching about global health.

Doret, welcome, and thank you for joining us.

Doret: Thanks Rosie. It's great to be here.

Rosie: We're glad to have you here. And we do feel very lucky that you are here to have a real conversation about equity and inclusion in health care, both in Canada and globally. This is obviously always important, but especially with the outbreak of COVID, I think there's been a lot more discussion, a lot more awareness, that's come up about inequities in our healthcare system, not just around the world, but especially in Canada. And I think it's going to be great to have your insights here with us today, not only from your expertise in pharmacy and patient care, but also just from living and working in and among vulnerable communities and the relationships that you've built with patients and colleagues.

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Safe Space Commitment

So before we really dive in, there's something I want to share with you, and you our listeners, on every episode. Some of what we discuss might be sensitive or challenging for us to say, and for our listeners to hear. But I really want us to have an open and genuine conversation. One goal of Changing Lenses is to be a safe and brave space for these conversations, and for us to be our real selves.

So Doret, I welcome you, and you our listener, into the safe space. And I invite you to call me out if I say anything inappropriate, or use the wrong terms.

Doret: Sure. Thank you.

Pharmacists: what you didn't know

Rosie: So Doret, maybe you could just start by sharing a bit more about your background. And here, I'm going to ask a really dumb question. Because I think everyone knows about pharmacists or probably most people do. Everyone's probably had to go to a Shopper's Drug Mart or a Rexall or something at some point and, you know, get some cold drugs.

So I, to be honest, when you told me that you work at a hospital, I was kind of confused. I didn't know why hospitals needed pharmacists because, you know, we just go to Shoppers Drug Mart and hospitals already have doctors, and the doctors are the ones who prescribe the drugs. So if there's a hospital with doctors, don't they already know all about drugs? Why do they need to have pharmacists on staff at a hospital?

Doret: Right. That's a very good question!

Rosie: OK, good! [laughs]

Doret: And a lot of people actually do get somewhat confused, when they see pharmacists at different institutions or various levels of the healthcare system, other than community pharmacy.

So legally for any prescription to be able to be dispensed to a patient, it requires the scrutiny of a pharmacist to make sure that, the medication is, appropriate and that the medication is safe for the patient.

And so if you go into a hospital, it's the same level of scrutiny, right? So whenever doctors prescribe within the hospital, every single prescription needs to be reviewed by a pharmacist, before those medications get dispensed.

And to be honest, I mean, I'm not saying that pharmacists are any more intelligent or anything than other healthcare professionals like doctors, but -

Rosie: Sure... [in joking tone,laughs]

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Doret: [laughs] But what I am saying is pharmacists obviously have such extensive training when it comes to pharmacology and pharmacotherapeutics compared to physicians. So just to give you an example, we focus a full four years or more on all things drug related. Whereas a physician may have maybe one course in a certain year on pharmacotherapeutics.

Rosie: Wow, that's a huge difference.

Doret: Yeah, yeah. And so there are a lot of nuances when it comes to medications and medication use in the treatment of different diseases. So, I think that there is an advantage to having someone with that extra training, reviewing the use of those medications.

And a big part of our role is also to provide education to patients or the larger population that are using medications, but also education to the prescribers. So, I think that interprofessional collaboration is really required when it comes to the overall health and management of health for her, for patients. I hope that makes sense.

Rosie: It does, yeah. And actually that's probably a good lead in to, maybe giving us kind of what the real life example of that would be. So like what does your job at St. Mike's look like then as the pharmacist on staff?

Integrated, collaborative, holistic healthcare: St. Michael's Family Medicine Clinic in Toronto

Doret: So, what I do is I work in a family medicine clinic, where it's a group of doctors who are under the umbrella of St. Michael's Hospital, and we are an academic family health team. And so my role there as a pharmacist is really as a consultant or an advisor to all of the healthcare professionals who work within the family health team, but also an advisor to all the patients who fall under that family health team.

A community pharmacist, just to contrast that, right; a community pharmacist basically gets a prescription in their hand, and then they dispense. And as they are reviewing the medication, they'll look at the information they have at hand in order to review that medication, to see if that's appropriate for you.

The difference that I have is that I'm often consulted on issues where a physician may not know what else they can do for very complex patient, for example, or if there are any other alternatives. They may not have all the information in front of them. And so I'm another source. So I guess you could say I'm kind of the pharmacotherapy specialist that's co-located for them so they can access me easily.

Rosie: I'm really glad that you're telling us all about this because like any person who doesn't know the healthcare industry well. Or I guess doesn't work in medicine so I don't see all the ins and outs. I just picture what I see on TV, right?

Doret: Sure!

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Rosie: On TV shows it's, you know, the doctors know everything and they throw out all these drugs. Oh, well, they have this disease. Well, I'll give them, you know, this "-gagagy", and you know, or the, and this "-cology", and you know, that "-ist", right. And they just seem like they have all the answers at the tips of their fingers and they know exactly the dosage. And I never see a pharmacist on these TV shows about doctors or medical practices.

So what you're describing actually sounds super interesting. You know, all respect to community pharmacists, but there's obviously much more to it than meets the eye. And it's not just about putting pills in bottles and handing them out. There's a lot of thought, it sounds like that has to go behind it. And that doctors actually don't know at the tips of their fingers, how to treat patients.

Doret: Absolutely. And, you know, the academic family health team that I work with is not something that is universally available to everyone, right. So I do work in a relatively unique practice, where there is access to all kinds of healthcare professionals, including social workers, including dieticians, including physiotherapists.

And so I think that I am very, very lucky and blessed to be able to work in such an interprofessional setting because everybody collaborates and forms sort of a care team around the patient and hopefully the different angles and different perspectives provides more opportunity to provide more holistic care for the patient.

What does “vulnerable” mean? Who are St. Mike’s patients?

Rosie: So yeah, before we talk about how you provide care, let's talk a bit about your patient base. Because actually until you started telling me about your work and the St. Mike's clinic, I didn't really realize the specific demographic that your patients often are coming from. So can you tell us a bit about what your patient base is like and who are some of the people that you see everyday?

Doret: Yeah. I mean, do you have all day Rosie? [laughs] Cause I could talk about it, just because, it's just such an interesting place to be. And the patients are really interesting and I love what I do. The original founders of St. Michael's Hospital were the sisters of St. Mike's. And they actually located St. Mike's Hospital, where it was, where it is right now, in the inner city. Their mission was to, take care or provide service to the population that needed it most. And so that's why they located it there. And so I think that kind of provides the background as to the focus and the mission of St. Michael's Hospital. But yeah, St. Mike's was founded on that premise, and originally was really there to provide care for the marginalized.

And before, you know, we would call it vulnerable populations. Over the last few years, I think we are trying to move away from the terminology of vulnerable.

Rosie: Oh, OK.

Doret: Yeah. And I mean, I had to go onto that journey as well because I use vulnerable quite a bit myself. But from reading and some of the research that has come out on this terminology, and a discourse that has taken place over the last couple of years, there's been a little bit more scrutiny, and reflection about why we use the word vulnerable. We do have at St. Mike's, Centre for Urban Health

Solutions. So there's a research group that does a lot of research around marginalized populations, urban health and inner city health.

So there was a paper that was published by Amy Katz. And she talks about the use of the word vulnerable in the public health literature. And we see that a lot across a lot of websites, a lot of strategic plans, a lot of grant applications. We see that a lot.

But what exactly does vulnerable actually mean, right? It's a very catchphrase, it's a very wide term. It's very vague, it's free floating, I think. And that's what she's trying to get at. It doesn't really get unpacked. And so how do you define what vulnerable is?

Rosie: So for sure, also a good conversation to have, because the word vulnerable to me gets lumped in a lot with marginalized populations, racialized populations. So actually, I'll just come out and say it and be blunt about it, cause that's what part of this podcast is. I assume when you say, you know, St. Mike's created to help needy and at the time vulnerable people.

So what I'm picturing are people that are homeless, people maybe that are drug addicts, who could also be homeless, or they're just drug addicts or people living in poverty. So, first of all, if we get more descriptive about what population group it is that St. Mike's is serving. How would you describe them? And then what is a better term than vulnerable.

Doret: Yeah, and you're perfectly right. I mean, those were the exact types of populations that we were talking about when we were using the term vulnerable. Now we want to get a little bit more specific.

And so we are talking about low-income populations, those who have mental health may have, addictions issues, may have issues with housing. And maybe they are racialized, and it could be the elderly who can't advocate for themselves who are home bound. Or they may have disabilities, for example. So I think that we are focusing in on the exact particular groups of people who may not have easy and ready access to the kind of healthcare that we hope to provide for them. So the goal is to try to level the playing field a little bit.

And so it does go on to say, many of the vulnerable quote unquote, or marginalized are often based on social status or socioeconomic status and not necessarily their age or the kind of health status or health issues that they may have.

Rosie: So, is this something specific in, healthcare that you mean, that we're trying not to use the words vulnerable or marginalized anymore because it's actually lumping too many disparate things together under one umbrella?

Doret: I think, you know, it's not to say that we can't use it and we shouldn't use it. I think that we need to use more specific terms like marginalized or racialized or, you know, just use the more specific terms when we're talking about, what population are we talking about? Because then it can provide some more clarity when we're trying to create policies, when we're trying to create strategic plans about what populations we'll be talking about. Instead of lumping them all under this one word vulnerable. So yes, we realize that it is being used a lot. And when we say vulnerable, it's a bit vague,

and then people just fill in the blanks, right. They may not come to the conclusion that you have, Rosie, about the kind of population that we're talking about.

Understanding patient histories – opioids and homelessness

Rosie: OK. Yeah. And that's helpful. And I don't want to harp on terms but I do think it's important. I think words matter and they're important. And I'm kind of asking questions on behalf of people who may have the same questions and don't know who to ask or where to ask them.

Maybe what would also put this in better light for people who just don't see what you see every day. And I'll say that I'm fully one of them, or I'll put myself first in line as one of those who don't encounter marginalized people and people at risk every day. Can you put some faces to these faceless patients for us, and maybe help us picture a bit better. Because again, just kind of thinking about stereotypes that might be out there. I've thought of this too and I'm not proud of it, but people don't have very good opinions about people who are homeless or living on the street or are addicted to drugs. And, I have thought this before myself and I've heard other people say it too.

"Oh, why don't they just get a job? Why don't they just stop using drugs? And you know, why are good taxpayers' healthcare money going to clinics like yours to care for people who seem to have problems that they should just be able to solve on their own?"

And even as I know this is not true, things are obviously much more complicated than that. So can you maybe help us see real patients, not by naming them, but by telling us a bit more about stories and people you've encountered.

Doret: Absolutely. I think I myself have been on a journey, so I really like actually how you named your podcast Changing Lenses because I feel like I absolutely understand questions that people have because I was there. And before having worked with this population, I also had those preconceived ideas. And I also had, you know, some assumptions that I had made and judgments that I had made prior to this. And so it's always a journey. It's a journey of learning and it's a journey of, oh, "changing lenses", right? And until you actually see a patient or see somebody and actually get to know them and talk to them and know what their background story is, it's really easy just to make some assumptions.

The reality of opioid addiction

I had a patient who had diabetes and also opioid addiction who lives in a relatively low-income subsidized housing. And the opioid crisis has made it really, really tough, actually. It's very much in the media, and it's brought a lot of prescribers to the point where they don't even want to prescribe these medications anymore because they don't want to make things worse, for example.

And this one particular patient would say to me, "I've been on these drugs for such a long time". And before they were talking about how you can never take enough, if you need it, you take it. There's no ceiling. And that's how the drug companies actually market it. And that was how it was marketed to all of the prescribers. And now it comes to this: people get stigmatized.

And so I entered into that conversation with her about trying to manage her diabetes, but then it ended up being that she started talking about her opioids. And I was trying to actually work with her on the opioid issue as well. But then, I asked the question, I said, "How did you get on it? What happened?" And she started telling me all of the trauma that she had experienced as a child. Sexual abuse all the way to her teenage years, and, you know, not having the kind of a family that was very supportive, and not having the resources to be able to get out of that situation.

And so her health ended up deteriorating because she wasn't eating well. And then she ended up getting osteo arthritis, and of course there's pain, fibromyalgia. And so the pain, then you start treating it with opioids. And then the dose of the opioids keep escalating to the point where now it's at such a high dose that the opioids are actually causing more harm than good.

And so, had I not actually heard about her history, I think I would have said, "No, no, you shouldn't be on these drugs, they're bad for you." And thankfully the physician actually knew about her story. And this is the great thing about working in the family health team I do is because they're so focused and intentional about learning people's stories that there's a lot of collaboration going on. And so when I learned about her story, I realized that that's not how we should be approaching getting her off these medications. We should really be discussing it and having more conversation around that.

And maybe there's also other things going on and where we may need to treat more of the trauma, the background trauma, and maybe refer her to other resources like social worker, to a psychologist. And get some of that managed rather than focusing in on the opioids, right? Because actually the opioids are not the issue. It's more of the background stuff. And how people experience pain is different too. If you've had a lot of trauma, if you have a mental illness, you experience pain so much more than someone without those issues.

Rosie: Thanks for sharing that, Doret. I think that that's a really good person to remember anytime we think of, "Oh, well, why don't they just stop? Why don't addicts stop being addicts? Why don't homeless people stop being homeless", or whatever it is. And it's never that simple, but I'm really glad that you were able to tell us about just one of your patients that you care for, because I think it really does help to bring some reality and hopefully compassion to the situation.

Doret: And that's just one story out of hundreds of stories. And so I think that it was very valuable for me to learn about this particular individual's background. And it's really hard to sum it up in one patient, but I will sort of describe a bunch of patients rolled into one.

Rosie: Sure, yes.

Healthcare for the homeless

Doret: And just to give you an idea what I learned and in particular, the fact that many of the patients that we do see have a lot of housing issues. And so they end up being homeless and sometimes they're homeless by choice, just because of the ability to get safe housing, there's a lot stacked up against people when it comes to being able to obtain safe housing. Which is why a lot of people just prefer to live on the streets.

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Rosie: Can you elaborate a bit more on that? Because that's kind of shocking me right now. So you're saying that somebody might choose purposely to live on the street rather than live in some kind of a building because living in the building would be worse. How does that happen?

Doret: Yeah. Yeah. I mean, public housing may not be the most ideal living environment. There might be, you know, bed bugs, cockroaches. Not the greatest living conditions, right? And also there might be more drug dealing going on, lots of noise, lots of people smoking. The environment is not the most conducive to being able to stay healthy and keep staying healthy, right? And so even if you can get public housing, which there's a huge, huge backlog to be able to get public housing and some funding to help with your housing.

And then what else can you resort to, if you can't afford housing? Then you resort to living in a shelter. And living in a shelter in an in and of itself is not particularly safe either. There's a lot of theft going on and violence going on. And so I think that it's a very intricate, complex issue. And so if it was you or I, and I've heard patients talk about this all the time, it's like, why would I want to live in a shelter? Why would I want to live in that environment when I can just be on my own and just sleep on a bench and just not be bothered by other people?

Rosie: So some of your patients have been homeless people then that have come in for health care.

Doret: Yep.

Rosie: And you know, it's really sad to say I see homeless people on the street , but I never really think about what their health issues are. I just, I was like, Oh, they're probably cold. They're probably hungry. And I don't think beyond that. So can you tell us what are some of the issues you've had to care for people about.

Doret: Yeah, the reality is, is everything to do with the social determinants of health, like their education, like their accessibility to other things and how marginalized they are. And 70% of people who are homeless have mental health issues.

I had a patient who was a very, very successful physicist actually. Working, and in the university, sort of college/university level, teaching. Brilliant man, and ended up having schizophrenia. And, this was a long time ago obviously, and not having access to the resources that he needed and he ended up getting homeless. And with untreated schizophrenia, you end up losing all kinds of your networks. You know, your natural networks, your friends, your family. And your behavior becomes such an issue that if you don't have the kind of network to be able to bring you or even access to a physician or a healthcare team that can recognize it, treat it - then you know, you fall through the cracks. And a lot of people fall through the cracks.

Rosie: Yeah.

Doret: So this is an example of one person and the type of medications that are needed to treat this condition is very expensive. And without access to the whole gamut of healthcare professionals and medications and counseling and all the specialists that are needed, it would be very difficult for this person not to fall through the cracks. And he did. Thankfully, he got connected with our team and

through the help of the social workers, through the help of a community mental health team that would go out to the community to visit him, make sure he gets his meds. I don't think he would be as plugged in and as engaged as he would be today.

Rosie: And how did he get connected with you guys?

Doret: Usually someone gets admitted to hospital. And at the hospital, if they recognize that they don't have a family doctor or they don't have access, they will try to get them. That's why at a hospital, not only do you have to have pharmacists, but you also should have social workers and physiotherapists and dietitians, all the whole gamut, you know. And social workers play a huge role when it comes to getting people plugged in.

And one of my most satisfying interactions are often working with our social workers, because we are so aware of the fact that people's health is not determined by biology. It's by and large determined by the socioeconomic aspects of their life. Yeah.

Rosie: So I'm trying to picture as a person who is blessed with a home to come home to when I get sick. Then I go to the local pharmacy, somebody gives me the medication, I bring them home. I take them, I read the instructions. I know what I'm not supposed to do with the medication. I know what I am supposed to do with medication. I follow it. And hopefully I get better.

With a person who's not only not having access to a home, so doesn't have anywhere to store the drugs, doesn't necessarily have food to take with drugs if they have to take it with food. And also a person who is schizophrenic or maybe has another mental illness where it makes it harder to understand or follow these instructions potentially, right? How does your family health team then ensure that they can get the treatment or they follow the treatment?

You did allude already about the social workers and kind of going out to make sure they're doing it, but like how do you guys deal with those challenges?

Healthcare equality is NOT equity

Doret: Yeah it's very dependent on what the need is, right? And so I think that here's where we can talk a little bit about when we, you know, we think that in Canada, we have a public, universal healthcare system.

And I gave this a little bit of thought and this is a topic that I teach my global health students as a baseline. That there is a difference between equality and equity. We talk about equity a lot, but I think that often we're talking about our concept of equality.

Rosie: OK.

Doret: So we want equal access to healthcare, which is all great and good, if all things were created equal. So you can have the same 65 year old man or woman with the same, let's say cancer condition, with the same sort of health background, but they're not created equal because they could have different income levels. They could have different literacy levels. And there may be a number of myriad of differences that are under the surface.

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And so if you say, if I'm going to give them equal care, which means for every single patient, I'm only going to provide 15 minute consult. Right? I'm being equal here, but based on the different, nuances of this particular patient, they may need more than 15 minutes of your time as a healthcare provider, to be able to get to the same point as the other 65 year old, who is literate and can read. Just like you, right? Will read all the details. Has the background of having some health literacy to be able to understand information as well. And so I think that equal is not equal to equity.

And so when we talk about equity, and I think all the more we're moving towards a more equity lens when we are talking about healthcare now, is that, how do we make healthcare more equitable? The universal healthcare system that we have in Canada is on the premise of equality, but it is not necessarily as much towards equity.

Rosie: OK. So I think what you've touched on is something that has come up more and more in mainstream media. And there's, you know, memes and pictures and different ways that people have described the difference between equality and equity, around race, around gender, around all sorts of things, including health. I think this is a really important piece to jump off on and to dive deeper into which I think we should do in a Part Two of the podcast, because there's, there's just so much there and we've covered a lot already in what we we've talked about today.

So to you who's listening to this podcast right now, I hope that you will join us for Part Two, where we're going to get into some really, really interesting discussions, and just thoughts about how our wonderful healthcare system in Canada is maybe not as wonderful as the Americans seem to think it is. And I think that's been coming up more and more in 2020 with COVID, but we're going to get it from an inside perspective. So, Doret, thank you for everything that you've shared with us so far, in Part One of our discussion around health equity and health equity in Canada. Thank you for sharing about your patients and your work day-to-day, which I know you're really passionate about. And we will continue this discussion in Part Two, as we start talking about equity and health.

Doret: Great, thank you.

Outro

[outro music plays]

Thanks for joining us – I hope today's episode helped to change your lens and expand your worldview. If you enjoyed listening, please rate and subscribe to Changing Lenses, available wherever you get your favourite podcasts. For more about how I'm changing my lens, please check out my website at changinglenses.ca. You'll also find the shownotes and transcripts for each episode, and you can leave comments or questions, or send me a message – I would love to hear from you!

I'm Rosie Yeung, inviting you to join me for the next episode of Changing Lenses. Until then, take care!

[outro music ends]

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