COVID 19: A Mini-Series Part 4: “Housing is Healthcare”

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Dr. Dosani: We saw that people were hanging by a thread for COVID. And then COVID happened and that snapped. And now we're seeing what that's doing in our communities and out across Canada, you'll see cities where the roads and streets are lined with encampments, people living outside and tents. And we need to do better and we can do better.

[chime]

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Mikaela Stiver: According to a recent poll commissioned by the Canadian Alliance to End Homelessness, one in 20 Canadians report having experienced homelessness at some point in their lives, almost as itself is arguably a public welfare pandemic of its own, affecting an estimated 235,000 Canadians each year. In part four of the rehabINK podcast COVID-19 miniseries, we explore the disproportionate effect that the COVID-19 global pandemic has had on people experiencing homelessness or structural vulnerability, as well as some of the measures that have been taken in Toronto, the Greater Toronto Area and beyond. My name is Mikaela Stiver and I'm a PhD candidate in the Rehabilitation Sciences Institute at the University of Toronto.

Analyssa Cardenas: And I'm Analyssa Cardenas and I'm a Rehabilitation Sciences Institute alumna. Today we are joined by Dr. Naheed Dosani, a palliative care physician and health and human rights activist, Dr. Dosani is dedicated to advancing equitable access to health care for people experiencing homelessness. Dr. Dosani also developed a palliative education and care for the homeless, a program of the inner city health associates. This program provides community based hospice palliative care to society's most vulnerable individuals, regardless of their housing status, or factors such as poverty or substance use. With COVID-19 Dr. Dosani’s leadership efforts also include serving as a medical director for the COVID-19 homeless response in the Region of Peel.

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Analyssa Cardenas: So thank you so much for joining us today, Dr. Dosani, we're super excited to have you online speaking with us. First, do you mind telling us a little bit about your work as a palliative care physician before the COVID-19 pandemic?

Dr. Dosani: Great. Well, first of all, thanks so much for having me, Mikaela and Analyssa. Thank you for including me and all the great work that you do on this podcast and beyond. Before the COVID-19 pandemic, you know, a lot of my work really did focus around providing palliative care and supporting people who are experiencing homelessness through the PEACH program, which is a mobile palliative care program that stands for “palliative education and care for the homeless”. I worked in hospital, in community, doing home visits, working in clinics to provide quality of life care for people with serious illnesses. And you know, on any given day, there's over 9000 people experiencing you know, street homelessness in Toronto and every one of those, there's 23 others were precariously housed. And so we know that you know, housing has a huge impact on health and well being and so Palliative care is really important. So I spent a lot of my time providing health care to people experiencing homelessness before the COVID-19 pandemic.

Mikaela Stiver: Fantastic. It's really amazing work. So thank you so much for everything that you do. As you know, we are from a rehabilitation sciences department and so one of our goals with this podcast is to highlight the often overlooked multidisciplinary nature of our field. It's my understanding too, that there are a lot of misconceptions around palliative care despite employing a similarly multidisciplinary model of care to rehabilitation. We were just wondering if you could speak a little bit about the relationship between palliative care and rehabilitation based on your experiences?

Dr. Dosani: Well, absolutely. And I think there's a lot of myths that exist out there around palliative care specifically, the most common myth probably is that you know, palliative care is often associated with death, dying, and particularly end of life care. And while end of life care is part of palliative care, palliative care is really an approach to care which emphasizes quality of life through the provision of pain and symptom management, psychosocial supports, emotional supports for the people we care for and their caregivers. And you know, as part of that, they say good palliative care actually is supposed to start right at the time of diagnosis of a serious illness and it's unfortunate in our communities, because of some of these missed that exists, palliative care is often provided quite late or not at all in communities across Canada. Because of this, we deal with people who are pursuing chemotherapy, we support people who are actively receiving dialysis, we support people who are on second or third lines of medications for their heart failure. And so absolutely rehabilitation and rehabilitation sciences are a big part of the work we do from occupational therapy support to support home safety and equipment in the community setting to scoring and assessing people's function, rehabilitation sciences are really important. Another piece that I'll speak to is the concept of survivorship. So there is a part of palliative care of people who actually survive and do well, and so rehabilitation is a huge part of that as well. Without rehabilitation. I don't think palliative care would be what it is. So definitely there's a huge link there.

Mikaela Stiver: Absolutely. And I guess I'm curious too, then do you work with a relatively multidisciplinary team in your role on a regular basis?

05:05

Dr. Dosani: Yeah, as someone who works in hospital and in community in both settings, I do actually work with a very large interprofessional team, which covers all our bases, including medical, nursing, rehabilitation, social work, care coordination, and these are very important elements of providing a palliative approach to care. Now, where we start to see some discrepancy is on the model. So you tend to see that in acute care, you might see a larger budget for that interdisciplinary approach or the rehabilitation sciences specifically. And this is where again, ongoing advocacy is needed to build up Home and Community Care supports, particularly for people who need palliative care in Canada, but that's part of the advocacy and the work that we need to do.

Analyssa Cardenas: Wonderful. That's fantastic. Thank you so much for sharing that. So what I'm really interested in is how you got into this field, seeing the intersection of working in palliative care, while also working with people who experience homelessness is definitely not something that I see every day. So I'm wondering, what was your inspiration for going into this particular field?

Dr. Dosani: Yeah, that's a really great question. Analyssa. I always knew I wanted to provide health care for people experiencing structural vulnerabilities and so I did an inner city residency when I was a resident at the University of Toronto. And while working at one of the shelters in downtown, I came across a gentleman who I was providing health care for his name was Terry, and he presented in pain crisis, and he was a young man in his 30s, and he had a widespread head and neck cancer. And due to, you know, his substance use and mental illness, he wasn't able to get access to the kind of care that he needed. He was diagnosed a year before I met him, but due to feelings of sadness, anger, and his mental illness, so the inability to organize for follow up and appointments and tasks, and the tumor group. So he started to experience pain and did what any one of us would do, he went hospital, the hospital and tried to seek the kind of pain control that anyone should have access to. Unfortunately, because of the stigma around homelessness, he didn't get access to pain medicine. So he found himself in our care. And as I started to build a rapport with him, which took some time, he promised me he'd start some pain medicines, and I got to the shelter the next day to help them with that. And I had learned that he had overdosed on a combination of alcohol and street drugs. So he had died by suicide. And he turned to the best pain relief that he knew at that time. This was a very traumatic event for me and I took some time away from my studies to reflect on this and I learned about palliative care. And I learned about the fact that people who live on the margins in our society don't access palliative care. That typically people who get access to palliative care, even in cities like Toronto, are people who tend to be from higher socio-economic background. And so I knew there was a lot of work to do. And so I didn't know what it was, but then I found it, it found me I guess, is a better way of putting it and the rest is history.

Analyssa Cardenas: Wow. That's amazing. Thank you for sharing that experience with us and thank you for I guess, acknowledging that it's okay to take time away from studies to really reflect upon our experiences and at the end of the day, it's what really helps us I guess, become better not just researchers, but better clinicians and like health care providers.

Dr. Dosani: For sure. I mean, you know, that—when that happened, it was like a crossroad. It's almost the expectation to just get up and see the next person and move on. And I'm so grateful that I was

around people and educators and a team that supported my decision to take some time away to reflect. We need to be reflecting on what we're experiencing, not just so that we can better pursue our career choices, but so that we can better serve the communities that we're meant to serve.

Analyssa Cardenas: Yeah, for sure. And so speaking of the communities that you serve, how has your work with a palliative education and care for the homeless, or PEACH, been impacted by the COVID-19 pandemic?

Dr. Dosani: The PEACH program is a mobile outreach palliative care program that has served hundreds and hundreds of people. We're a team of four palliative care doctors, a nurse coordinator, a health navigator, working within the home community care team with a home care coordinator to provide pain and symptom management, emotional support, home and community care, no matter where a person is often in unorthodox environments. So not a typical home when we say home, a shelter supportive housing, emergency housing, an alleyway. And so that was challenging before COVID. It got even more challenging, after COVID. I think a lot of the solutions, if you looked at the palliative care kind of literature, what people were saying on Twitter who do mainstream palliative care will use virtual and that's great, but virtual doesn't always work, particularly for people who live in poverty, or experience homelessness. I just I do want to say that we did receive a donation of mobile phones, and we were able to digitally connect some of our clients who were interested in that. So we did take advantage of that where possible, we saw a huge impact. But what we saw is that the people that we serve, were already hanging by a thread and that thread had snapped after COVID. People were more likely to be on the streets living in encampments, respites, shelters and drop ins, bless them. They did their best, but to abide by physical distancing, many of them had to reduce their services reduce the amount of people who were allowed in the building around the facility, reduce their hours or even close in some cases. And so when you depend on such supports for housing, food, social supports and your mental health, they can get really challenging. And so we saw a lot of that, because we deal with a very sick population, we saw that people were progressing through their diseases with less supports than they would normally get. And that was very traumatic for obviously, the people we care for. But for our own team to witness with our own eyes, there was an emotional distress that we saw on the team. And so these are just some of the things we're seeing. We also saw this scenario come up where many people we care for, were given options to stay in shelters are moving to hotels and motel programs, but they just felt safer to be outside and living in encampments.

10:45

Mikaela Stiver: I think that's very interesting to you that you brought up the point about individuals feeling more comfortable being outside and I was curious, based on your bio, I understand that you have taken on a new role as a medical director for the Region of Peel COVID-19 homeless response. Can you tell us a little bit about how you got involved with this work and the importance of the work given the disproportionate effect of the pandemic on people living with homelessness or in vulnerable housing conditions?

Dr. Dosani: No problem, the COVID-19 pandemic addressed a lot of new information that people and sometimes new responsibilities too. And I had the honor and privilege of taking on this new role with the Region of Peel to work as the medical director for the Region of Peel's COVID-19 homeless response.

And on any given day, there are between 1000 and 1400 people actually who are utilizing the region's shelter and housing services, not to mention that, you know, we know that there are a larger number of people who are precariously housed. So it has a more suburban homelessness profile, we're very familiar with like the big cities in Canada, and what that can look like, you know, panhandling or you know, large emergency shelters in inner city areas, but suburban homelessness is different. And it has its unique challenges. And so I was tasked with the responsibility of working with the Region of Peel and local government and building up a team of health professionals and social service providers to develop a plan to support people through COVID. And what that kind of boiled down to was four areas. The first was promoting physical distancing, by encouraging people to support their journeys into hotel and motel accommodations that the Region of Peel accommodated for. And so that was a decision that was made very early on and it was an important decision that was made, we've now supported over 50% of people in the Region of Peel who experience homelessness, or either staying in hotels and motels, that has allowed us to really support physical distancing. The second is mobile scaled up testing, so working with our paramedics, teams, in local nursing teams, we were able to be mobile in the way we support testing. So going to shelters and supporting on site testing. And the third is creating an isolation program, so if people are waiting your test results, they have a place to say that safe trauma informed provides health care. And then finally, the development of a recovery program where people who do actually test positive are able to receive adequate social and medical supports, but built into the recovery program is a pathway to housing. It's been challenging, but I feel that we've grown a lot and been able to meet the community's needs.

Mikaela Stiver: Needless to say, you have been very busy, it sounds like.

Dr. Dosani: It's been a very busy time. That's true.

Mikaela Stiver: For sure. I'm curious if there's anything unexpected that you might have learned during your time working with the Region of Peel that you think maybe even carry over into your own work in palliative care?

Dr. Dosani: Yeah, I mean, you know, it does cause us to pause for reflection. Along the journey, I started to realize that people were being offered these accommodations in hotels and motels and for many people experiencing homelessness, whether it was in Peel, and like programs like the one I've developed in Peel, I've developed across Canada, in different jurisdictions. And I've talked to colleagues like, you know, the people we're caring for, would get access to a space that they could call their own with their own bathroom and their own sleeping arrangement, and their quality of life went up, and their health improved and their mental well-being improved, and all of the above. And I started to think okay, so this is great. For all these years we've been talking about there isn't enough money, there isn't enough pressure to house people. And then the pandemic comes along, and all of a sudden, there's this incredible capacity for all levels of government to work with activists, health workers, social service organizations, to actually house a significant proportion. Not everybody, but a lot of people experiencing homelessness. And I was like, how come we couldn't do that before? Actually, like I've written about that now in a couple places, just to say like we actually do have the capacity to end homelessness in Canada. And I think that's the crossroad we sit at now amidst COVID because we've shown the ability to develop these programs, we've shown the ability to house people experiencing

homelessness. What are we going to do when this pandemic is over? We're going to send everyone back to the street and send them back to the shelters? A, that's not the right thing to do. I think that's fairly obvious. And B given that we've built this infrastructure, this is a very opportune moment to build affordable pathways to high quality housing for people to experience homelessness because housing is is a human right, housing ishealth care, it's the right thing to do, and there's never been a better time than now. So that was probably something that I learned.

15:09

Mikaela Stiver: Fantastic. And actually, it speaks really well to a conversation that we had just before we hopped on to start recording with you talking about the fact that, you know, housing is such an important foundational block for people to be able to build their lives, you know, if you have that basic security, it's much, much easier to find a job, to be able to support your family, whatever it may be. And yeah, as you said, we've seen that the governments across Canada have been providing these accommodations. So how do you think this is going to change as the urgency of the pandemic fades? What does that look like when you know communities are wanting to take their hockey arenas back or the community centers, or the hotels are getting filled up? How can we continue this fantastic progress? Without you know, sort of putting a pause on everything else?

Dr. Dosani: You know, Mikaela, that's a really great question. It's literally like the question of this week, perhaps even today, and having conversations with colleagues across the country. And we've been, we've been working with the Canadian Alliance to End Homelessness to advocate for this plan, and it for the listeners, please look up the Canadian Alliance to End Homelessness, Recovery for All and there's an open letter that's come out from health workers across Canada, basically promoting this six step plan that really emphasizes how we might be able to support the end of homelessness through COVID recovery and engaging the federal government to say," listen, part of COVID recovery for this country is ending homelessness". And the six step plan talks about, obviously, the creation of housing units, but it also talks about the collection of data and having more information around race-based data, for example, which really is an issue because we don't actually understand how systemic racism is impacting homelessness. We know that, you know, nearly two thirds of people experiencing homelessness in Toronto are black, indigenous, or people of color. And that doesn't get talked about a lot. That kind of thing is super important, recognizing the right to housing from an indigenous perspective, and ensuring that indigenous communities are driving those processes. But also some of the skewed policies that allow for rental rates to go up so quickly, and having some more control so that we have more affordable housing available for Canadians coast to coast at baseline, we have a choice, you know which path we're going to take, and I hope we take one that includes, you know, housing as a fundamental part of any COVID recovery plan for this country.

Analyssa Cardenas: Absolutely. So you spoke a little bit about how COVID-19 has further magnified these socio-economic disparities in the Greater Toronto Area and across Canada. So part of the goal of this podcast miniseries is to also explore the global impact of COVID-19. So how do you think this, in Canada or the GTA, has compared to like other countries across the world?

Dr. Dosani: I think one thing's for sure. COVID-19 is not just highlighted inequities, it's literally perpetuated existing inequities. And so there's this common thread and I see it in different sectors, and

people talk about it that COVID-19 is impacting people equally, or it has impacted people equally. That's the furthest thing from the truth. That's just not true. COVID-19 is like a guided missile that targets people who live in poverty, and particularly people of color. And what it has done for people in my position, and other activists who I work with, is it's been a very unfortunate and tragic circumstance, of course. But given that it's happened, it's been an opportunity to provide communication around some of the issues that we've been talking about for a long time, including social assistance rates. A national housing strategy, how to better support people who use drugs in our communities. Ontario seeing upwards of 55 deaths per week around drug overdoses. And of course, racism and the effects of systemic racism. We know in Toronto that 83% of COVID-19 cases affected black, indigenous, people of color. And you know, a lot of people are suspecting this a lot of the people I work with, but this is very surprising to a lot of policy makers. This is the same province where, you know, health leaders, including from our premiers office, were saying, “We don't need to collect race based data” at the beginning of this pandemic. And then look, they did and look what they found. But that's why these issues are important to talk about and discuss. And we have actually seen trends like this, across the country and around the world, we've seen the same disparities for people live in poverty, people who lack housing and people of color in the United States and other countries around the world. And so we have to be cognizant of these factors. And as we move forward into COVID recovery, I'm hoping that we take these lessons and be implement them in our strategies. It even goes down to like some of the most basic things like there was the COVID-19 app that was developed, which is a great initiative, but when it turns out is that you need the latest kind of phone and the latest iOS or equivalent on whatever platform you use, and a lot of people I care for, they don't have those kinds of phones or they don't have the latest phones, they don't update their OS’s. So then we develop this contact tracing tool that we're really banking on and hoping the people who are most likely to be targeted by COVID-19Cannot structurally access it. What does that say? Right, you know, questions like that come to mind.

20:06

Analyssa Cardenas: Yeah, I think it really speaks to like, where the priorities are and like where we should be prioritizing in terms of developing all these strategies to implement to reduce COVID. And it's interesting, because I feel like in a lot of our interviews with our COVID-19 miniseries, a lot of what we're talking about is, you know, transitioning into online or like online care, but when you think about who has access to those things, there's a huge discrepancy and those who can. So it's always something to be cognizant of.

Dr. Dosani: You know, I think COVID also has made the discussion about privilege really tangible, right? I think before it may have been some abstract thing you talk about, you know, even in our back to school plans, right? There's a lot of discussion about homeschooling, and learning pods are all the rage, but I provide health care to a lot of working families or people who live in poverty, you have children, and they say, to me, “Listen, like it must be nice for people who are privileged to talk about learning pods and homeschooling” but people in poverty don't have those options. You know, if equity is not front and foremost, in our COVID-19 recovery plans, what future will our children have in this case? And what does that say about us as a society? So I'm really hoping that the equity lens is applied through the next phase as we go through COVID-19 recovery and beyond.

Mikaela Stiver: It's very much on our radar also. And I think it's interesting how, in a pandemic scenario like this, people are even more afraid to, you know, say the P word, can't say privilege, because everyone is struggling. And of course they are. But it's understanding that not all struggles are equal, and that it's not even just the struggles, it's the supports that are in place to help these people. I don't mean to ask a loaded question. But would you mind, in your words, sort of defining what systemic racism and systemic inequity mean to you?

Dr. Dosani: I think systemic racism is the accumulation of decades, perhaps even more long experiences of trauma, loss, discrepancies, and inadequate supports for people who are of color. And it's everything from the one on one interactions that people have around racism for people of color, particularly, you know, anti-black and anti-indigenous racism, to the ways that policies are developed. An example that's currently happening that I think is near and dear to my heart, because it's something I'm advocating around is around policing, policing as a public health crisis. And as a good example of what systemic racism looks like, people who are black are 20 times more likely to be shot in the city of Toronto by police as compared to their white counterparts. And we see statistics like this, you know, every single day, in cities across Canada and around the world. And so that's one kind of example. But we see, you know, systemic racism also has a role to play in other aspects of healthcare, including as a palliative care doctor, something we talk about a lot pain management, we know that, you know, in our medical education system, we're actually training trainees of the future, they actually think black people have a higher tolerance for pain as compared to white people, and therefore, they're less likely to receive pain medications. We have evidence to show that, you know, individuals with metastatic cancer who are black are much less likely to be prescribed the same amount of opioids as their white counterparts. And there's a lot growing body of evidence to show inadequacies in racism, even pain management. And every field you go in, you're going to see that race is a factor and it's, it's not rates, that's the factor, it's racism that’s the factor, we need to remember that. So I think, you know, going on a very high level conceptual approach is important because it allows us to have these conversations about systems and systemic racism. But we must never forget that it boils down to these real tangible things on the front lines for people of color.

Mikaela Stiver: That's really interesting, actually, that you brought up the pain side of that, because it's been quite a hot topic for the last little while in medicine when it comes to physical presentation of disease. And saying, you know, in our textbooks, we only have pictures of, say this skin disease, what does psoriasis look like on an individual with darker skin than the one example that we have in our textbook, but it speaks to the fact that it goes so much deeper than that, where it's applying to a field like palliative care as well. So thank you for sharing that. I think that's something that most people don't think about it at all.

Dr. Dosani: I think every area of healthcare is, is having its day of reckoning around this. And this is a true conversation that's happening in all aspects of medicine and healthcare. And so for those who are listening, remember, it's not about race that's causing these discrepancies. It's racism causing these discrepancies.

Analyssa Cardenas: I think that's always important to consider in terms of how we communicate to each other in the words that we choose. So thank you for that. I was wondering, a lot of our listeners

are students, what advice do you have for young professionals or students who are interested in advocating for social justice within the healthcare sphere?

24:48

Dr. Dosani: I just want to start by saying I'm so blown away at the next generation of trainees that are coming through from all different ages and spaces and previous careers and talents and walks of life. I have a real optimism about what the future looks like, including yourself. But I have to say that the first step as it probably should be anytime you're trying to advocate for people is to listen and learn, you know, listen and learn first. And although the PEACH program was an initiative that our team initiated, we spent about a year and a half learning about the issue and listening to the clients we serve. We had a client centered approach, and we included client Advisory Council to guide us in the development of the program. For example, learn the literature become the expert on what the issues are out there. But that doesn't say that you have to, you know, wait five years before you talk about something. At the same time, feel free to engage. And I think what's really great about 2020, albeit in a pandemic, while we can't hang out and see each other physically is it's a digital world. And I think, you know, advocacy has different forms, I think engaging in social media is really a powerful tool, I've taken to Tiktok and Instagram and Twitter to, you know, get my message across. And even if you do engage in social media, like have a purpose as to why you're doing it. It's not just about follower counts, and likes, and whatever metric, you know, you got to ask yourself, what it's about. For us, a lot of the work that we do on social media is about changing policy to support people who experience structural vulnerability. So you know, whether it's a post raising awareness about systemic racism, and police brutality, or a post that, you know, showcases the benefits of housing, improving people's health. The last piece is, you know, try to dovetail that advocacy with your own clinical work and the work that your clinical work produces, which may include research, for example, or quality improvement project. And then finally, like, my last piece of advice is always to- when you're thinking about advocacy is to role model the kind of advocate that you would want to be because the next generation of trainees are watching, and they're probably smarter than you, Oh, I know, the next generation is way smarter than me, and, you know, give back and give back to so that we can enable and build capacity for activism in the future, the kind of activism that we really need. So I'd say those are some key principles to really think about.

Mikaela Stiver: That makes a lot of sense. I just wanted to ask a quick kind of follow up to that in terms of, you know, advice for people who are in interested in getting involved in sort of raising their voices on issues that matter. There has been a bit of backlash on social media about armchair advocacy, and you know, how much of it is self-serving versus how much is actually having an impact? Do you have any thoughts on that?

Dr. Dosani: Yeah, I think that that discussion is really warranted. You know, I have to say that if you're truly engaged in advocacy, it means that you're willing to share your privilege. So it's a privilege to be able to advocate for yourself, and get on Twitter and say something and have people respond or write an article and get a response. But when push comes to shove, are you willing to give up some of your power and privilege if you are a person that comes with privilege and privilege takes different forms. But if you're willing to give up some of that platform, and some of that privilege for the purpose of supporting the causes that you claim to support, then that to me is a recipe for, you know, appropriate advocacy in the modern era. I'm very cognizant also in these discussions that not every person

listening this podcast is going to work on a PEACH program constantly on overdrive, supporting people who are in dire, dire need. Like some people are going to end up working in hospitals, and some people will work from home care, and some will work in private practice, but maybe through your professional life, you will have experiences with inequities and you will, because of your ability to be not an armchair activist, but an actual person who's willing to share their privilege and give up their privilege, you'll step in and step up, and maybe that will happen. Or maybe it won't be in your professional life, it'll actually be as a concerned citizen that cares. And the next time you see the news, and you see people protesting the development of a shelter in your neighborhood, you'll go out and oppose that view. I think it's important for people like me to not make this kind of work so impossible to engage. It's possible that you don't have to do you know, years and years of studies to do this work. And you don't have to be a street doctor to believe in this work and support this work. On the flip side, you have to be willing to engage and give up some of your power and privilege if that's what the cause needs. Great question.

Mikaela Stiver: I think we should use that as our litmus test moving forward to just sit back and reflect a little bit and say, “am I doing this for the right reasons?” And if that's the case, then honestly, who cares what people are saying about you on social media?

Dr. Dosani: And you know, I've reflected a lot on this question. And sometimes I've realized that depending on the issue, and what's going on, sometimes it's better for me not to say anything. And sometimes it's better to amplify the voices of those who are experiencing what they're experiencing. And that's why a lot of the press that we've had over the years about the PEACH program, we've done everything we can as much as one can to bring client experiences to the stories. Like you know, look up stories about the PEACH program, you'll see these are the people we care for. And yeah, you know, we might be in the background or be associated with the stories but where possible, especially around systemic racism and experiences of racism, it's important to amplify voices of those who experienced these traumas, and to give them the opportunity to have their voice heard. So, you know, amplifying people's voices is a great way to be anti racist and support the cause actively.

30:03

Analyssa Cardenas: For sure. Yeah, I think you know, a lot of what I've learned recently is not just about saying my opinion or saying what I think about a situation, but it's always listening, learning and like interacting and engaging with those who actually are experiencing the traumas and acknowledging that, you know, it's a privilege to not have that sort of lived experience that everyone else has. So thank you for that. Yeah, that was really good advice. So we've recently seen a shift in how people are approaching social justice and healthcare issues. So beforehand, it may have seemed like, these are two very distinct and separate issues. But now we're starting to see that in many ways, social justice and health care actually overlap and are interconnected. So how do you foresee the role of healthcare professionals or even general healthcare education change as this intersection between the two becomes more evident?

Dr. Dosani: Yeah, and I think you're speaking to there has been historically, this kind of resistance to people to work in health care around activism in, for example, addressing the social determinants of health, there's even campaigns we've heard about, like in the states around ‘stay in your lane’ kind of comments, I'm really disturbing commentaries. But I'd say that advocacy and health equity is and

should be, first and foremost, a foundational principle of any, you know, health care system. And that goes without saying, I think there's been a lot of focus in recent years about the social determinants of health and how we live, learn, work, and play. We know the number one determinant of health outcomes, for example, is income, followed by a list of factors which include education, social network, housing, food security, you know, and that's, that's all fine and dandy, but I think the thing with the social determinants of health is it's quite like a static thing. And it's like, okay, that's what it is, but what creates inequities in the social determinants of health? And that requires us to dig up the roots and really think about the structural determinants of health. And when you dig deeper, then it becomes political and Virchow in 1848 said, you know, “medicine is nothing but politics on a grand scale”, right? And so, at the end of the day, if you really want to address health inequities in our communities, we have to talk about racism, we have to talk about colonialism, we have to talk about ableism, we have to talk about transphobia, xenophobia, and what is actually at play from a systems perspective around the structural determinants of health. There is a long history of advocacy in medicine and healthcare, it is not a new thing, there often is a counter current, we have to continue to be out there and putting our voices out there, whether it's supporting new Canadians, refugees, and asylum seekers around the migrant health movement, whether it's around advocating for housing for people experiencing homelessness, whether it's decriminalizing drugs for people who use drugs, or you know, advocating for social assistance and guaranteed income to address poverty in this country. These are ultimately the social factors take root and have their hugest impact in their health care outcome. And ultimately, these are public health crises that we need to be thinking about. So the ‘stay in your lane’ movement is often one that is put up by people who want to create dissenting voices. And as health workers, we have privilege, privilege in our ability to do the things we do but also be there with people in their most vulnerable times and see things from a healthcare lens, and the ability to see things from a healthcare lens allows us to be strong and able advocates, and so you know, it's one in the same and advancing health equity for our communities is essential. Social justice is essential. How can you really have healthy communities without?

Mikaela Stiver: Most definitely, and I can't help but notice, I think maybe we've all sort of noticed, to some extent that a lot more of these conversations have been coming out since the pandemic hit. But I'm curious, we've had this conversation with a few of our other guests, and they've all had some really interesting things to say about it. Do you think that in the grand scheme, there might be some positive things or some silver linings that might come out of this pandemic, in terms of just people being more willing to actually talk about these things and speak up about these things? Are we as a society actually starting to learn our lesson? Maybe?

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Dr. Dosani: That's a great question. I think on one hand, it's really great to see that there's so much more discourse about race, about people who use drugs, about housing, about income supports for people, because I don't think these topics were getting the same, you know, support in mainstream media as they were. It's also great to see that now there's a greater drive to collect data around some of the things that we just talked about. But it's one thing to talk about things. And it's one thing to collect data around, around these items. It's another thing to act right? And until we start to see that we are a collective, and a collective community, I don't know that we're going to really see the action that we want to see. And so I hope that the COVID-19 pandemic highlights these issues, but also drives

policymakers, activists and government essentially to work together to inspire this change. There's never been a better moment to have the impacts that we're hoping to have. And so the time is most certainly now. And that's why you're seeing a lot of people who I really admire and work with, you know, advocating for the kinds of social change that we need in our communities. And so it's a great point of the times now.

Analyssa Cardenas: Yeah, I've been seeing a lot of that online, people saying, like, “we're witnessing history, we're gonna be in like the history books”. Well, what side of history Do you really want to be on? Now is the time to be, like you said, taking that action. So speaking of action, what do you want our listeners to know or take away from this conversation? So what actions can our listeners take to help address the barriers and the challenges that people living in vulnerable housing situations are facing?

Dr. Dosani: Yeah, I think I'd like people to walk away with the fact that people experiencing homelessness are arguably Canada sickest sub-population, they're 20 times more likely to have hepatitis-C, five times more likely to have heart disease, four times more likely to have cancer, they die at a rate that's 2.3 to four times higher than the average Canadian baseline population. And the average life expectancy for people experiencing homelessness in Canada is 34 to 47 years old, their life spans are half that of those who have housing. And so housing literally saves lives, right. And so, you know, to recognize the poor health outcomes that homelessness has on people is important, but also to recognize that when we talk about housing, and we're advocating for housing, it's a health intervention, it will not only make people feel better, but they will live longer, right? And so that's why there's such a force around supporting housing, and of course, the nuances of the housing, affordability, the quality, the supports that go with it, those are more nuanced conversations. But I think that's really key, and we need to do better. And so people can do better by advocating checking out the Canadian Alliance to End Homelessness website, checking out their Recovery for All campaign, signing the letter and advocating to your members of government, both, you know, locally, but provincially. And also federally. At the end of the day, this actually affects all levels of government, and all levels of government have a role to play. So I think that's really key. We've talked a lot about racism, too. And I will say that, you know, a lot of people who want to do a lot of good work, I think we talked about amplifying voices. So I will echo that where possible, amplify voices of black, indigenous people of color, support black businesses, support indigenous businesses, and where possible, for sure, be an advocate, but share your power and privilege. Give up your power and privilege. And that's really the first step to being an anti-racist person. It's not a good enough to be non-racist, we need to be anti-racist at this time. So you know, those are a couple of thoughts addressing people experiencing homelessness and the racism and public health crisis that is plaguing our communities as well.

Mikaela Stiver: So some fantastic take home points. And I think that it gives our listeners regardless of what their means may be some concrete things that they can look into to actually take some action, whether it's just retweeting someone, or whether it's making a small donation, there is something that we can all do to support those who are less privileged than we are.

Dr. Dosani: Amazing.

Mikaela Stiver: Wonderful. Well, thank you so, so very much for spending the last hour with us chatting about your work. It's incredible work to hear about and thank you for sharing all of your experiences with us.

Analyssa Cardenas: I feel very privileged and very lucky to have been able to have this platform to speak to you on and I definitely learned a lot myself just listening. So I'm sure our listeners will also appreciate that. So thank you.

Dr. Dosani: Well, thank you. Thank you Mikaela and Analyssa. I really appreciate that I'm truly honored and thank you for using your platform, this podcast to advocate around issues like this and raise awareness. It's really important. I know you guys will have very bright futures.

[chime]

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Mikaela Stiver: Thanks for tuning in for part four of the rehabINK podcast COVID-19 miniseries. This initiative has been generously supported by a COVID-19 student engagement award from the University of Toronto.

Analyssa Cardenas: We hope you enjoyed this episode on how the pandemic has impacted the lives of people living in structurally vulnerable conditions. Stay tuned for future episodes, and be sure to check out the rehab Inc podcast on Podbean, Spotify, Apple podcasts and Google Play.

Mikaela Stiver: If you'd like to read more about rehabbing our student led research driven digital magazine or rehabilitation sciences in general, you can visit our website at www.rehabinkmag.com that's R-E-H-A-B-I-N-K-M-A-G dot com.

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[chime]

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