Interview with Dr. James Owen

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Dr. James Owen
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Dr. James Owen is a family physician at St Michael's Hospital and an Assistant Professor in the Department of Family and Community Medicine in the Temerty Faculty of Medicine at the University of Toronto. His clinical practice focuses on HIV primary care and prevention, 2SLGBTQIA+ health, and the care of vulnerable populations. He is a previous 2SLGBTQIA+ Health Theme Lead for the Temerty MD Program, as well as the director of the second-year "Complexity and Chronicity" course.

UTMJ: Hello Dr. Owen, please tell us a little about yourself.

JO: I have been a family doctor in a large academic family practice at St. Michael's Hospital in Toronto for the last 10 years. My clinical and academic interests include 2SLGBTQ care, HIV primary care, STIs, and inner city health. These interests first developed in medical school, when I completed an elective at the Sherbourne Medical Centre with an LGBTQ healthcare team. It was an instant fit in terms of the kind of work they were doing, where my head was at the time, and the kinds of populations I wanted to work with.

UTMJ: How do the social determinants of health (SDOH) impact your practice?

JO: I think that the SDOH impact health more than we recognize. Issues like food insecurity or income challenges can undermine everything else we hope to achieve working with these patients. There are many things that my team and I do as healthcare providers to support our patients in terms of their SDOH. For example, for people living with chronic conditions, disability, or HIV, we may fill out paperwork to allow patients to access the Ontario Disability Support Program (ODSP) to support medication access and improve their financial situation. I can think of one patient of mine with mental health challenges who was to be evicted on Christmas Day, and our team – much kudos to my social work colleague in this case – worked to secure his housing and ODSP approval. Many folks who are marginalized, younger, or with mental health issues or co-morbid medical conditions don't have private drug plans and medications are a necessity for these people to be healthy. We know that the better a person's status in terms of their SDOH, the better their healthcare outcomes.

UTMJ: What does it mean to work with inner city health and how has this changed over time?

JO: Inner city health is often used as a broad term to refer to care of more disadvantaged patients, as historically the inner city is where we've seen these populations over-represented. Now the term "inner city health" has changed due to gentrification, so we see many wealthier and employed people who are moving to the inner city. So even though we consider inner city health as part of our practice, our practices are changing over time and some of our more disadvantaged populations are being pushed to places in the city where housing costs are lower, but sometimes harder to reach. Regardless of where you practice, everyone is going to have patients that experience inequities related to SDOH. Where you are located and the type of practice you develop will determine the proportion of your practice that is significantly affected by SDOH-related issues.

UTMJ: How has COVID-19 impacted access to your practice and patients?

JO: First, COVID-19 revealed the digital divide between people with access to technology, access to phone or video services, and the capacity to use it. Pre-COVID, we would tell our high-risk patients that if it is difficult to reach us or if they need something urgently, walk into the clinic anytime and the nurse or duty physician would find a way to squeeze them in. Of course, we can't do that with virtual appointments. COVID presents a lot of challenges to our most at-risk patients. First, do they have a phone number, are our records correct, and can they stay on hold for 20 to 30-plus minutes to book an appointment? Some have chaotic lifestyles where they may not be able to book appointments in advance or answer a call at the time they were booked. We still allow some higher-risk patients to walk into our clinic, and both the screeners and the front desk are made aware of them to allow them to be seen without an appointment. Second, some patients have lost jobs or had their hours cut back, which poses significant challenges to accessing health services from a financial perspective. Third, both from research and anecdotally, I can say lockdowns and the consequences of COVID have led to mental health difficulties such as depression or anxiety. For patients who either had pre-existing mental health conditions or co-morbid health issues, overlaying mental health challenges makes the management of both conditions even more complex.

UTMJ: How has virtual care impacted your practice?

JO: I think the transition to virtual care has some positives. For example, for those that don't live in the downtown core, virtual appointments make it easier for us to stay in touch and order testing at their local lab. Patients appreciate when they don't have to take a half day off work to come downtown to see me for a 15-minute appointment. But there are also many challenges. In my practice, I do a lot of sexual health care where we need in-person components, particularly to collect swabs and do lab samples. With us not being as easy to access, some patients aren't coming as frequently for testing. Last summer when things relaxed a bit, we started seeing higher rates of positive STI diagnoses as more people came in for testing. On top of this, our testing is often reliant on public health. Gonorrhea and chlamydia testing use very similar swabs and reagents as those used for COVID testing, and there has been a global shortage of STI testing swabs, which has led to us rationing our resources for extra-genital testing. Considering the populations at higher risk of STIs and the lack of resources to screen them, we worry about missing things. Together, we have a number of issues: reduced resources, reduced accessibility, perhaps even losing contact with some of our high-risk folks, which perhaps means later presentation for testing and treatment of STIs or missed diagnoses altogether.

UTMJ: Is there a way to reconnect with some of these high-risk patients?

JO: What we did early in the pandemic is actively identify patients who are higher risk and try to re-engage with them. We had lists of patients at higher risk of being isolated during the pandemic, and members of our team called them to check in. This helped to identify issues where we might offer support. I would get messages saying things like: "This patient was struggling with depression. Can you call them back and discuss their antidepressants?" It's a proactive approach as opposed to always having the patient initiate contact.

UTMJ: How do some of your patients feel about all these changes?

JO: COVID has been a challenge for everyone. One patient who I can think of – they identify as nonbinary – for them, the connection to community was particularly important. But after losing their job during the lockdown, they had to move far outside of the downtown core to stay with family members who are somewhat but not entirely supportive of their gender identity. So, you have family stressors, income stressors and now unfortunately this person has been isolated from their social supports as well. It's just one story among many of the challenges that COVID has presented to our communities.

UTMJ: As part of a large Family Health Team, could you tell us about the role of interprofessional teams in addressing the SDOH?

JO: I could not do the work I do without the support of my incredible colleagues! An example that comes to mind is a patient who is HIV+ with a history of depression. He lived in poverty, struggled with the impact racism had on his mental health, and has difficulty accessing medications and healthcare services. If he is feeling particularly down, he might stop his antiretrovirals, which can negatively impact his health. My nursing colleagues, who are often more available that I am, and I share his care. I have a dedicated HIV pharmacist who tries to ensure he maintains access to medications and their adjustments when necessary. The social worker on our team had provided counseling support and worked to connect him to other community resources as well. Within our team, we are fortunate to have a dedicated HIV nurse, pharmacist, and social worker who all work together to support people living with HIV in our practice. Our whole team shares an electronic medical record, making it easier for us to communicate and coordinate care. While this is just one example, we know that patients with complex care needs tend to be much better managed by interprofessional teams.

UTMJ: How can we approach these systemic barriers that minority groups face from accessing healthcare?

JO: I think the first step is awareness. I think it is encouraging that there is increasing awareness by healthcare providers about the SDOH and how COVID-19 has disproportionately impacted our more disadvantaged patients. The next step is actively thinking about how to address inequities when working together with patients and colleagues. I've learned a lot by asking patients about how they're doing and what impacts the pandemic has had on them, and then working together to identify how I can support them. This has opened my eyes to what I can do as a healthcare provider, and the role that we can all play. Finally, we should all understand that tackling these challenges is part of our job. I keep an eye on Twitter (@DrJamesOwen), and I see a community of colleagues who increasingly recognize that addressing inequities should be part of our roles as professionals. We need to recognize we have the privilege of being respected voices that we can use on behalf of our more disadvantaged patients.

UTMJ: How do we best approach the policy gaps that negatively impact your patients?

JO: We need to involve patients in the design of our health care systems. A small example: at our family practice, we have almost 40,000 patients represented by a patient advisory panel. These panels are intended to reflect our diverse patient populations. Of course, it's harder to ask someone to participate in the panel if they don't have the time and resources to do that. Regardless, this is one organized way

patients can share with us what they need from healthcare providers and provide input into policies and services regarding our Family Health Team. Our team has also been doing work to address anti-Indigenous and anti-Black racism within our department. This will be an ongoing and sometimes uncomfortable process, and not easy.

More broadly, I think it's important to recognize that while we do our best to work within the current systems, there are a lot of insufficiencies and inequities in our social support systems. I think those who advocate for broad systemic change are moving in the right direction, and I'm one of those people. For example, a fair and liveable minimum wage, greater financial supports through ODSP and other social programs (or abolishing or rebuilding those programs altogether), introducing things like universal basic income, and "housing first" types of policies. If we want systemic change at a policy level, this is where we need to be focusing our attention. Of course, this is a huge task, but all health care professionals can play a role in this type of advocacy.