Interview with Dr. Rachel Spitzer

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Dr. Rachel Spitzer

Dr. Rachel Spitzer is a paediatric and adolescent gynaecologist at Mount Sinai Hospital and Associate Professor in the Department of Obstetrics and Gynaecology cross-appointed to the Dalla Lana School of Public Health at the University of Toronto. Her clinical practice focuses on adolescent and pediatric gynaecology, global health, and contraception. She is a prior Global Health Faculty Lead for the Temerty Undergraduate Medical Education Program as well as Vice Chair of Global Health in the Department of Obstetrics and Gynaecology.

UTMJ: Tell us a little bit about yourself.

RS: I was born in Montreal, raised in Toronto, and graduated from McMaster medical school 20 years ago. I completed my OBGYN residency training at the University of Toronto followed by a one-year fellowship in pediatric and adolescent gynecology at SickKids. Since my undergraduate studies, I have been quite interested in global health, specifically global women's health. I had some opportunities through medical school and residency to engage in clinical electives in Eastern and Southern Africa and Asia, which led me to do a master of public health at Harvard University with a focus in international health. I then returned to the University of Toronto where no one had that same academic focus at the time. For the past 13 years, I have practiced general obstetrics and gynecology at Mt. Sinai. I am also a part-time pediatric and adolescent gynecologist at SickKids, and I coordinate their adolescent obstetrics program. More recently, I lead our university department's clinical involvement in the AMPATH program in Kenya.

UTMJ: Especially considering your work with adolescents, how do the social determinants of health affect sexual health and how do they present in your practice?

RS: First off, I would say our numbers of adolescent pregnancies is small at SickKids (20 to 30 babies a year), but the social acuity and morbidity, and trauma histories are quite significant. Many of the young women we see have a lot of mental health issues, and much of this has been exacerbated by the COVID-19 pandemic.

Overall, some of my pregnant patients began their journey with great enthusiasm, but months in, perhaps having lost income or being placed in insecure housing, the prospect of having another person to feed and clothe can be economically challenging, socially challenging, and extremely stressful. People who you expected to help you care for the child may not be available or may be unable enter Canada, and we may see them less for prenatal care.

At the end of the day, the social determinants of health significantly impact access to care. The reality of living in downtown Toronto may be different than living in Northern Ontario, which is different than in the Maritimes. So, although [abortion] care is covered by our provincial care plans, if you're a teenager with an unwanted pregnancy in Northern Ontario, for example, and there's no care provider anywhere nearby, you may have to leave your community and cover the associated economic expenses. Of course, this is also exacerbated by a pandemic where everyone is asked to stay home.

UTMJ: What is the biggest access issue your patients face regarding their sexual health?

RS: I think access to contraception is a huge issue. Some of our residents launched an advocacy campaign called Cover ContraceptiON, which lobbies the provincial government to provide free contraception during the COVID-19 pandemic and beyond. The challenge now is many young people are unable to easily ask for or access contraception. For example, some may be home with parents and unable to discuss their contraception needs, yet they are potentially still involved in sexual relationships. Additionally, it may be harder to access clinical services such as IUD insertion if clinics aren't open as often, and the current economic uncertainties may make it harder to pay for contraception. Certainly, some patients presenting with unintended pregnancies or requesting abortion care are direct consequences of the lack of access to affordable, attainable contraception. Thankfully, abortion care has been reasonably well prioritized and understood at this point in the pandemic and there have been studies looking into no-touch abortion where all the care is provided virtually using

medications. However, for surgical procedures, hospitals now have barriers like requiring a COVID-19 test one to two days beforehand and preventing support persons from entering with patients.

UTMJ: How has virtual care impacted your practice and what does this format mean for diverse populations?

RS: There are advantages and disadvantages to virtual care, though I do think that post-pandemic, virtual care is here to stay. Some patients are thrilled to be seen virtually. Why come and wait in my office when you never even needed a physical exam? For example, I see some young women who are disabled for menstrual suppression to improve their quality of life. I'm always happy to see them, but sometimes the transport down to the hospital and waiting for an appointment can be challenging and may not contribute significantly to the interaction.

On the flip side, if I'm seeing an adolescent in-person, we take the opportunity to privately speak to them about confidential matters like sexual relationships, gender identity, substance use, home safety, etc. On the phone, it is difficult to be certain the conversation is confidential. Patients who may be experiencing intimate partner violence may not be in a safe and confidential space to reveal anything over the phone. Additionally, some patients may not have good access to phones or may share a phone. Access for people who speak different languages can also be challenging. We have translation service tools over the phone, but without visual contact and non-verbal clues, the conversation can be more difficult.

Furthermore, the switch to virtual care has led to delays in physical examinations. I even had a patient who presented with irregular periods and after bloodwork discovered she was 20 weeks pregnant. If it wasn't for the pandemic, there are things we might not have missed or would have found sooner.

UTMJ: How does COVID and virtual care impact patient outcomes?

RS: Overall, I think we're a little bit worse off, though it depends on the situation. For example, my elective surgical patients are waiting inordinate amounts of time. While things like incontinence procedures aren't lifesaving, these services significantly improve quality of life.

One of the negative changes during COVID-19 is the lack of support persons that attend the hospital with patients. If a patient wants their partner to call in virtually, we can, but it's different from having them in the room, especially if it's a surgery or a termination of pregnancy, for example. In terms of pregnancy, partners are often feeling more removed from the experience. A small silver lining is that if patients must come alone, I can create a confidential environment to discuss safety and the status of their relationship, but at the end of the day, individual care is less family-centred.

For things like colposcopy to assess for cervical cancer presence after a positive screen, many clinics have limited the number of patients they can see. For patients who have already been told they're at risk of having an abnormality that requires further assessment, increased wait times can be stressful.

In the future, we will lean towards hybrid models. Virtual care diminishes geographic barriers, but anyone would acknowledge that it has limitations. I can't listen to babies or do gynecological exams virtually, though these considerations vary by specialty and area of practice. However, we are seeing the impacts of exclusively virtual care during this pandemic, and we should recognize its shortcomings.

UTMJ: You mentioned you work with newcomers to Canada – what are some unique challenges in working with this population?

RS: Our Women's Equity (WE) Clinics [at Women's College Hospital, Thorncliffe Park Community Health Centre, and the Scarborough Centre for Immigrants and Refugees] represent three different collaborations and include newcomer immigrants, refugees, and sometimes uninsured women. Mostly these patients are referred and have previously interacted with the healthcare system, but in terms of sexual health, unfortunately, the CMAJ newcomer guidelines are quite minimal. Sure, from a cancer prevention perspective, we ensure their Pap smears are up to date or initiated. But as a whole, we need to be conscious about our assumptions. If someone is single or has a partner in a different country, it doesn't mean they don't have sexual partners [here].

One example I've seen is a refugee woman whose refugee claim was based on being gay, and you may assume they would not require contraception. However, some people maybe for social reasons or due to a more fluid gender identity may still have sex with men or may even seek pregnancy. We should leave all our assumptions at the door and approach them non-judgmentally.

UTMJ: How is Canada different compared to other countries and what barriers do women face in other countries that are underappreciated?

RS: Each country is unique with differences between regions and personal circumstances. In some countries, access issues around sexual health can be enormous. In many countries in the southern hemisphere, abortion remains illegal and access to abortion care can be difficult. This is separate from whether an abortion is safe or not, though

generally when abortion is illegal, safe abortion access is limited.

In addition, in Canada, we are fortunate to have a socialized medical system, which is different in many resource-limited settings where people often pay out of pocket for any form of care.

Age of consent is an important issue in many countries. In Canada, we are fortunate that we have no age of consent, and anyone who can demonstrate their capacity to understand a procedure or medication can access it. In other countries, there is an age of consent. If you are undergoing an abortion procedure, for example, you must either be a particular age, get consent from your parent or guardian, or you have to take the case to court.

We should also not discount educational attainment, which is not mandatory in many countries, and the connection between education and health.

Finally, many countries have stigmas associated with intercourse outside of marriage, LGBTQ health, and transgender health. Sometimes, speaking about your gender identity may be risking life and limb as these perspectives are illegal or highly stigmatized. So, we are not perfect in Canada, but we are incredibly fortunate.

UTMJ: How can healthcare professionals best approach interactions with diverse populations?

RS: Let the patients guide you. By taking a good non-judgmental open-ended history and learning what the patients' goals of care are, we can begin to help them. For example, we should be mindful of countries that may practice female genital mutilation, asking specifically – perhaps in their own language – if they have experienced this, of course being mindful of potential associated trauma. This can be relevant to their sexual function, their future reproduction, or just to help guide your physical exam. I can't know every cultural background and circumstance, but my patients have been my best teachers. At the end of the day, we should continue to work with like-minded individuals to ensure the literature, educational opportunities, and awareness for our trainees in primary care and in women's healthcare are strong.