The role of medical students’ training and community placement as a tool to enhance medical education in Canada

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ABSTRACT

We are currently witnessing unprecedented crises on an international scale linked to synthetic opioid overdose fatalities. While most governments and health policy makers have focused mainly on combating the current crises through harm reduction strategies, little focus has been given to the role and training of future doctors in evidence-based practices of harm reduction and addiction medicine. Therefore, enhancing medical student’s training in the implementation of addiction medicine, and the establishment (or expansion) of medical students, residents and post-fellows’ community placement—via partnerships with organizations that provide specialized care to patients struggling with mental health and addiction—would strongly improve the health and well-being of marginalized populations.
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Background

In 2016 alone, overdose mortalities in both Canada or the United States (U.S.) linked to the introduction of synthetic opioids such as fentanyl into the illegal drug market have now surpassed the total number of U.S. soldiers killed during the Vietnam war (Duggan, 2017; Jarrett, 2017; Wood, 2018). Most jurisdictions and local health authorities in Canada have implemented various methods to contain the current drug overdose epidemic, such as free naloxone distribution, public awareness campaigns, and overdose prevention sites (Thomson, Lampkin, Maynard, Karamouzian, & Jozaghi, 2017). The province of British Columbia (B.C.), being one of the first and hardest hit provinces, has also established holistic drop-in-centers in Vancouver for mental health and addiction (Jozaghi & Bird, 2018). In addition, it is the only North American city to provide hydromorphone-assisted programs to small groups of patients (e.g., 300 patients) (Jozaghi & Dadakhah-Chimeh, 2018; Thomson et al., 2017). The majority of funding and the focus of health authorities and government policy makers has been directed toward preventing overdose mortalities (Jozaghi & Dadakhah-Chimeh, 2018).

However, there has been scant attention being drawn toward the role of physicians in evidence-based harm reduction and addiction medicine and their contributions to the management and prevention of the current overdose crisis (Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). Previous studies have highlighted the effects of negative stigmas and attitudes of health professionals toward people who use illegal drugs, subsequently resulting in detrimental consequences for a patient’s diagnosis, treatment, and recovery (Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Jozaghi & Dadakhah-Chimeh, 2018; Neale, Tompkins, & Sheard, 2008).

Skill deficits of physicians

The negative attitude and stigmatizing behaviors toward people who use illegal drugs by medical practitioners, specifically physicians, have been linked to a lack of knowledge and clinical experience which in turn not only diminishes the quality of care but also decreases the likelihood of patients to seek adequate health care (Ball et al., 2006; Eaton, 2004; Neale et al., 2008). It is not surprising that over the past few years the global burden of addiction and mental health costs have increased substantially, and that many people who use drugs (PWUDs) drop out of care before their course of treatment has been fully completed (Eaton, 2004; Whiteford et al., 2013). While opioid addiction fulfills the criteria of a chronic illness such as diabetes, it is not very difficult to treat when compared to other chronic ‘lifestyle diseases’ (Martyres, Clode, & Burns, 2004; Mertens, Weisner, Ray, Fireman, & Walsh, 2005). Granting its increasingly prevalence in the health-care settings, routine screening and treatment for opioid addiction remains far below other chronic illnesses, giving the health-care professionals the perception of its challenging nature (Martyres et al., 2004; Mertens et al., 2005).
There is growing recognition in Canada and abroad for the need to improve the skills and practices of physicians when dealing with patients who may have unhealthy substance use and addiction issues (Hering, Lefebvre, Stewart, & Selby, 2014; O’Connor et al., 2017). For example, the creation of the examination for the American Board of Addiction Medicine, the certification for the Canadian Society of Addiction Medicine, and more than 37 addiction medicine fellowship programs are some of the ways that health policy makers have attempted to address current health-care crisis (Kunz & Wiegand, 2016). However, there is still an urgent need for an increase in the number of trained physicians to meet the current demands of PWUDs (Hering et al., 2014; Kunz & Wiegand, 2016; O’Connor et al., 2017).

Training/education of medical students, residents, and post-fellows

Addiction medicine is an important medical specialty in a multidisciplinary field that enhances the processes of screening, diagnosis, treatment, education, and advocacy (Polydorou, Gunderson, & Levin, 2008). There is growing acknowledgment and awareness amongst institutions concerning a lack of sufficient substance use and addiction medicine curriculum in undergraduate medical programs (Polydorou et al., 2008). Furthermore, there is an increase in the mutual understanding that graduating residents should demonstrate necessary competency in managing substance abuse cases (Polydorou et al., 2008). Polydorou et al. (2008) recommend expanding the curriculum for medical residents, emphasizing the connection of addiction medicine with qualified faculty, improving the coordination of scheduling amongst different branches in the medical faculty, and most importantly, increasing clinical exposure via harm reduction and addiction medicine training. Due to the extensive evidence surrounding the reluctance of many PWUDs to seek medical help from primary health-care providers – due to stigma, inadequate access, lack of transportation, and homelessness (Jozaghi & Marsh, 2017) – there is a need for medical schools to have required clinical placements within community organizations that provide on-the-ground social services. This will not only enhance the clinical experience of physicians but also improve the health care experiences of PWUDs. This is especially relevant, as historical trends reveal that PWUDs have obtained a majority of their health-care needs via supervised injection facilities or peer-based networks (Bouchard, Hashimi, Tsai, Lampkin, & Jozaghi, 2018; Jozaghi, 2015a; Tyndall et al., 2006).

There is also growing evidence of the effectiveness of peer-based models of public health initiatives (Jozaghi, Greer, Lampkin, & Buxton, 2018). These include the Vancouver Area Network of Drug Users, the Western Aboriginal Harm Reduction Society, the British Columbia Association for People on Methadone, the Eastside Illicit Drinkers Group for Education, the SALOME/NAOMI Association of Patients, community clinics, detox centers, overdose prevention sites, and the highly beneficial outcome of networks and partnerships between public health providers who provide specialized care to patients struggling with poverty, mental health, and addiction (Bouchard et al., 2018; Goodman et al., 2017; Jozaghi, 2015b, 2014; Jozaghi et al., 2018).
Conclusion

The economic cost of untreated substance abuse and addiction-related illnesses has now surpassed cancer and diabetes combined; however, there continues to be a vast shortage of addiction physicians in the health-care system (Hering et al., 2014; Kunz & Wiegand, 2016). In fact, very few physicians practice addiction medicine on a full-time basis, and a large deficit in knowledge of evidence-based addiction medicine and harm reduction models among medical residents and general practitioners have contributed to the negative stigma of PWUDs when accessing care (Kunz & Wiegand, 2016; Polydorou et al., 2008). This has been especially detrimental for Indigenous patients with substance abuse needs (Jozaghi & Dadakah-Chimeh, 2018). These individuals have been the most significantly impacted cultural group to suffer from health-care discrimination, as well as from a lack of cultural knowledge and consideration by primary health-care providers (Evans, White, & Berg, 2014; Goodman et al., 2017).

There have been several important developments in recent years, such as the research fellowship in Addiction Medicine, the St. Paul’s Hospital Goldcorp Addiction Medicine Fellowship, the establishment of new clinics that are tailored to the needs of Indigenous patients, a new federally sponsored initiative to build collaborations in Addiction research, and the application for the first Canadian certification in Addiction Medicine (Hering et al., 2014; Klimas et al., 2017; O’Connor, 2018). However, the training of the next generation of physicians cannot be successfully completed and practiced unless medical schools can effectively facilitate a partnership with drug-using communities. Therefore, enhancing the community placement of medical students and residents will greatly improve the health and well-being of marginalized populations.
Letter to the editor

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