Bringing health care to the homeless

If the mountain won't come to Mohammed, then Mohammed will go to the mountain.

That's the underlying philosophy of a new program that brings general and mental health care to 5 Toronto hostels for the homeless and a detox centre. The Shared Care – Hostel Outreach Program is an initiative of the Centre for Addiction and Mental Health, the Queen Street Mental Health Centre and the Toronto Hospital.

Dr. Clive Chamberlain, vice-president of mental health programs at the Queen Street centre, says the program is vital because of the growing number of homeless people using hostels. Many of them have serious mental health and addiction problems, and are in poor physical health.

Most hostel workers do not have the skills to cope with these problems. At the same time, most hostel users don't have up-to-date health cards and can't apply for one without an address. As a result of this catch-22, they are shut out of mainstream health services. But even if they had access to the system, many homeless people are reluctant users because of previous experiences.

Chamberlain says these obstacles can be overcome by providing a user-friendly system within the hostels and at the detox centre. Each of the 6 sites has a nurse, an outreach worker, a part-time family physician and a consulting psychiatrist. Physicians are paid a salary, getting around the need for clients to have a health card to receive services.

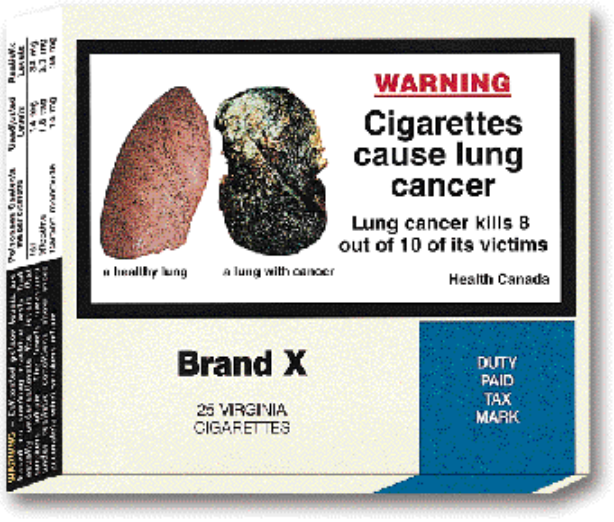
The outreach worker strikes up a conversation with clients, identifying those who want or are obviously in need of health care. The nurse attends to immediate problems and is the link between client and family physician. The family physician consults with the psychiatrist on diagnoses and the prescribing of appropriate psychoactive medications, or arranges an appointment with a psychiatrist.

"Having a visiting psychiatrist is highly desirable," says Dr. Robert Frankford, the family physician at the Seaton House men's residence. "It makes me feel better about how I practise, that I'm not working in total isolation. It's nice to be able to consult, get advice on prescribing practices, get help with psychosocial problems."

For many patients, says Chamberlain, receiving health care can be the first step toward getting back on their feet. Once stabilized on appropriate drugs for physical or mental health problems, good case management can lead to suitable housing and steer those who are willing into alcohol, drug or risk-reduction programs, and eventually provide help with finding employment. "These people especially require tailor-made solutions," says Chamberlain. "Off-the-rack solutions just won't work."

People who stereotype the homeless as people with inherent character weaknesses shouldn't be too smug, he added. "This program is important because any one of us is just a fine line [away] from the same fate through a piece of bad luck — losing a job or family and social supports, or bad health. We've seen doctors, lawyers, priests and nurses end up on the street for a variety of reasons. This can happen to anyone." — © *Olya Lechky* Toronto

Coming soon to a store near you?



Six shockingly frank cigarette packages, including this one, were unveiled recently by the national Tobacco OR Kids campaign. It was launched by a coalition of more than 150 health organizations, including the CMA, that want the federal government to require the tobacco industry to adopt the packages. Results of a focus-group study released by Health Canada reveal that smokers want a "gloves-off" approach with respect to tobacco risks. The 6 packages feature photos of clogged arteries and mouth cancer, and information about addiction, child health and causes of death in Canada.

OMA, CMA trailblazer retires

Dr. Carole Guzmán, a trailblazer for women physicians who has a passionate interest in the evolution of Canada's health care system, retired in May after spending more than 6 years as the CMA's associate secretary general.

She served the organization for 20 years, beginning as a committee member in 1979 and becoming a board alternate in 1984 and a board member in 1988. She was president of the Ontario Medical Association in 1989, and 2 years later assumed the CMA presidency. Guzmán was the second woman to head both these organizations. She was also president of the Federation of Medical Women of Canada from 1981 to 1983.

Barbara Sibbald

Dr. Carole Guzmán: time to relax

Guzmán, who graduated from the University of Toronto in 1958, is an internist specializing in pulmonary disease. She did research and practised rehabilitation medicine at Ottawa's National Defence Medical Centre for 22 years. She also developed a care model for patients with chest disease that is still used today. In 1992 she quit her practice to assume the CMA post, but she continued to teach at the University of Ottawa.

Guzmán became involved in organized medicine because she felt the profession was being "assaulted" by politicians, economists and others. She vowed to help improve the environment so that "physicians could do what they were trained to do." She adds that "the profession has a role in helping society make decisions."

In retirement, she plans to pursue her hobbies and volunteer work and spend more time with her family; her husband, Tony, is a neurologist, and her first grandchild was born in June. She still plans to do limited consulting in health policy and professional issues. — *Barbara Sibbald, CMAJ*

Make technology work for you

The new *Alberta Doctor's Guide to Office Automation* offers physicians practical advice on using computers to enhance patient care. The 28-page booklet, produced by the Alberta Medical Association, provides an overview of software, the Internet and email, electronic patient records, levels of automation, implementation and cost.

AMA President Rowland Nichol says office automation has become "an invaluable part of ensuring consistent, ongoing quality patient care." Possible applications include monitoring for drug interactions and patient recalls, supporting clinical care, conducting literature searches and making charts more legible and comprehensive. The guide is free to the AMA's 5700 members; others may purchase it for $10 (plus shipping, handling and tax) by calling 780 482-2626 or by contacting ama_mail@amda.ab.ca.

MDs needed to cope with "extreme brutality" in Sudan

The African Medical Association of Scandinavia (AMAS) is making a special appeal for aid for the western and eastern parts of Sudan. Some 2 million people are affected by the "bloody and protracted conflict in Sudan," states the association, which is seeking voluntary health care workers, medicine, medical equipment and cash contributions. "There is compelling evidence of attempts to ethnically cleanse the Nuba peoples from this region. . . . These people are totally helpless in the face of extreme brutality."

AMAS is particularly concerned about the "total lack of state institutions" in Sudan. In the Nuba Mountains, for example, there are 2 German "housemen [not fully qualified] doctors" working in "extremely primitive conditions." They are providing care for about 500 000 civilians widely dispersed over 7 counties. There is no vaccination program and no sanitation or clean-water projects.

AMAS is planning a 5-part project that includes improved sanitation, creation of a piped water supply, a comprehensive vaccination program, nutrition education and primary and emergency health care. Specific initiatives will include sending 1 doctor to each of the 2 regions, training volunteers to provide vaccination, clean water and sanitation, training traditional midwives in family planning and providing food.

AMAS was established in 1991 and has 109 members, 29 of African descent. It hopes to act as soon as possible. "It is after all a matter of life for tens of thousands of people," the organization said in a letter to CMA President Allon Reddoch.

AMAS is a registered charity. For information contact AMAS, PO Box 511, S-581 06 Linkoping, Sweden; dr.a.kangoum@ebox.tninet.sefax.

Pulse

Where have all the nurses gone?

Recent data from the Canadian Institute for Health Information (CIHI) indicate that the total number of registered nurses employed in Canada dropped by 3.4% between 1993 and 1998, falling from 235 630 in 1993 to 227 651 in 1998. Because of a growing population, this represents an 8.3% decrease in the number of nurses per 100 000 Canadians.

Registered nurses employed in nursing per 100 000 Canadians

Province	1993	1998	% change
Nfld.	891.4	986.3	10.6
PEI	937.8	933.0	-0.5
NS	986.4	911.2	-7.6
NB	1002.5	990.3	-1.2
Que.	832.5	773.1	-7.1
Ont.	784.5	687.3	-12.4
Man.	915.8	893.2	-2.5
Sask.	832.6	823.4	-1.1
Alta.	812.5	746.7	-8.1
BC	754.6	696.4	-7.7
Yukon	-	778.3	n/a
NWT	796.2	782.8	-1.7
Canada	816.3	782.8	-1.7

Source: Canadian Institute for Health Information

Although half the provinces showed gains in the overall number of nurses employed between 1993 and 1998, only Newfoundland showed an increase in the number of nurses employed relative to population. Ontario experienced the largest decline, with a 12.4% decrease per 100 000 people. In that province, there were 5518 fewer nurses in 1998 than in 1993.

CIHI also found that the nursing population in Canada is aging, with 25.5% of nurses being 50 years or older in 1998; 5 years earlier, the comparable figure was 20.7%. At the other end of the scale, the proportion of nurses under 30 decreased from 14.2% of the total in 1993 to 10% in 1998.

There has also been a significant change in the profile of employment opportunities for registered nurses. An increase in the availability of casual part-time positions has increased the proportion of those working part time from 39% in 1993 to almost half — 48% — by 1998. The proportion of nurses working in the fields of community health and home care also grew, from 9.2% in 1993 to 11.5% in 1998. The proportion working in hospitals had fallen to 62.4% in 1998, down from 67.3% in 1993.

This column was written by Lynda Buske, Chief, Physician Resources Information Planning, CMA. Readers may send potential research topics to Patrick Sullivan (sullip@cma.ca; 613 731-8610 or 800 663-7336, x2126; fax 613 565-2382).

Breast cancer treatment and older women

Fifty percent of breast cancer cases now involve women older than 65, but are these women victims of ageism when it comes to research, diagnosis and treatment of the disease? This was one of many issues explored at a recent Vancouver conference on breast cancer treatment involving older women.

Sixty-five-year-old women can expect to live another 18 years and 75-year-old women another 12 years, said Dr. Sharon Allan, head of medical oncology at the BC Cancer Agency in Victoria. But treatment for breast cancer within this age group can be controversial because most clinical studies have not included older women. Treatment decisions have to be made in the context of other illnesses and the women's social situation. Ageism — the feeling that these women are not worth treating because of their age — should be avoided as a rationalization for withholding treatment, Allan said.

Studies show that older women undergo screening mammography less often than younger women and are less likely to have breast-preservation surgery. However, cancer detection from mammography is more common in 65-to-75-year-old women than in younger women. Dr. Noelle Davis, head of surgical oncology at the Vancouver Hospital and Health Sciences Centre, said these women should have mammograms biannually, and after they reach age 75 if they are healthy.

Davis said one study showed a 40% reduction in breast cancer in older women who took tamoxifen prophylactically. Tamoxifen is "very well tolerated in older women," Davis concluded.

Although older women are less likely to receive appropriate therapy for breast cancer, most cope well with radiotherapy and surgery. Davis said a lot of myths surround the use of radiotherapy for this age group; for instance, women with osteoporosis can receive radiotherapy if the body is positioned carefully, although the use of chemotherapy remains controversial because there are no good data.

For frail, elderly patients, Davis said limited surgery, such as lumpectomy, can be done under local anesthetic, and should be followed by radiotherapy. The future, she concluded, "presents a great opportunity for better screening and prevention efforts" in older women. — © *Heather Kent*Vancouver

Research Update

Rapid defibrillation boosts survival following out-of-hospital cardiac arrest

A relatively inexpensive tune-up of communities' emergency response programs can significantly increase the number of patients who survive cardiac arrest outside hospitals.

In a controlled trial set in 19 urban and suburban Ontario communities, researchers found that changes designed to ensure that portable defibrillators were on site within 8 minutes yielded a 33% increase in relative survival among cardiac arrest victims (*JAMA* 1999;281:1175-81). Survival to hospital discharge rose from 3.9% to 5.2%. Study author Dr. Ian Stiell says this is the equivalent of another 21 lives saved annually in the study communities, or approximately 1 life for every 120 000 residents.

Existing defibrillation programs were optimized by cutting times from call receipt to treatment, speeding up ambulance dispatch and having firefighters — who are typically the first on the scene — apply defibrillation. Establishing the rapid defibrillation program would cost an estimated $69 000 per life saved, with annual maintenance pegged at about $3500 per life saved.

Stiell and colleagues compared outcomes for 36 months before and 12 months after the rapid defibrillation program was implemented. Before the changes, 77% of victims received treatment within the 8-minute "window of opportunity"; after the enhancements, 92% of patients received defibrillation within this window. There were 4690 cardiac arrest patients in the "before" group and 1641 in the "after" group.

"We've shown quite clearly that just having the machines is not enough," says Stiell, a self-titled emergency medicine health services researcher with the Ottawa Hospital's Loeb Health Research Institute. "You have to get them [defibrillators] to victims quickly. I see this as a challenge to all North American communities with populations under a million. I suspect most don't know what their survival rates are, or response times, or even their CPR rates."

The study, phase II of the Ontario Prehospital Advanced Life Support (OPALS) project, was funded by the Ontario Ministry of Health. The communities involved, which had populations ranging from 16 000 to 750 000, were part of an umbrella emergency medical services system that offered basic life support and defibrillation. Stiell is now studying the additional impact on survival of advanced life support measures (intubation, intravenous lines and drugs). — © *Greg Basky* Saskatoon

Quelling the controversy over needle exchange and high HIV rates

Controversy has surrounded needle-exchange programs for injection drug users in Vancouver's Downtown Eastside neighbourhood since recent studies showed high rates of HIV infection among drug users participating in the programs. This question was recently revisited by Dr. Martin Schechter and his colleagues in a study designed to find out whether the programs contribute to HIV transmission by promoting needle sharing and other high-risk behaviours, or simply attract participants who are already involved in high-risk activities (*AIDS* 1999;13:F45-51).

A total of 694 intravenous drug users who were HIV-negative when they were recruited and had injected illegal drugs within the previous month participated in the project. The researchers set up a storefront office in the Downtown Eastside, where 80% of the subjects came for at least one follow-up visit. The researchers found no evidence that needle-exchange programs resulted in drug users forming new needle-sharing partnerships. Only 1 of 498 subjects said he or she had met new needle-sharing partners through the needle-exchange programs. The increased infection rate among people using the program was consistent with their pre-existing higher-risk profile. The researchers also point out that Vancouver's Downtown Eastside was "a haven for intravenous drug users long before needle exchange." As well, needle-exchange programs are just one of a range of services needed for HIV prevention, such as methadone maintenance and adequate housing.

The study's findings follow on those of a previous study (*AIDS* 1997;11:F59-65), which found that of 1000 injection drug users, those who had participated in the needle-exchange programs had significantly higher rates of HIV infection than those who did not attend the exchange. Those results were interpreted in the US to mean that the programs promote increased HIV infection rates. The US government still refuses to fund needle-exchange programs. — © *Heather Kent* Vancouver