Shine a Light on Stigma Podcast

Transcript - Episode 6: Stigma and Substance Use Disorder - A Conversation with ED Physician Bobby Redwood (Pt.1)

Note: The Shine a Light on Stigma Podcast is produced for the ear and designed to be heard. This transcript is intended to augment the recording.

This podcast is part of a series that explores ways to eliminate stigma and help people with substance use disorders access the medical care they need. Produced by Superior Health Quality Alliance and Telligen, Quality Innovation Network-Quality Improvement Organizations under contract with the Centers for Medicare and Medicaid Services, an agency of the U.S. Department of Health and Human Services.

Brittany Rodriguez: Hello and welcome to the Stigma Podcast. In this podcast we're talking about the ways that stigma impacts people living with substance use disorder. We aim to inspire and empower our listeners to shift away from the culture of stigma towards one that promotes healing and recovery and a supportive and respectful way. I'm Brittany and I'm here with Mia, who will soon be introducing our special guest today. But first, I just wanted to quickly remind you to go back and review those previous podcasts. There are quite a few now that we've been going along. And today we are actually going to break this into two separate podcasts. And so, this is going to be part one. Also, if you have any feedback, we would love to hear from you. We want to hear what you have to say. And you can do that by emailing us at stigmapodcast@telligen.com. And that is all lowercase all together and you can find us at any of your favorite podcast streaming services.

Mia Croyle: Thanks, Brittany, and I am so excited today to introduce you to our guest. We're shifting gears a little bit and we're going to talk with a clinician focus a little more today than we have been. And so we have invited Dr. Redwood to join us. Dr. Redwood is a physician improvement advisor for the Wisconsin Hospital Association. His quality improvement portfolio includes opioid stewardship, medications for opioid use disorder, and reducing stigma around substance use disorder. Sound familiar? Dr. Redwood also serves as the physician lead for the Midwest Alternatives to opioid programs, the Wisconsin Dental Pain Protocol, and a Tri-state coalition to reduce opioid overdoses in long-term care settings. Clinically, Dr. Redwood is an emergency medicine physician, and he serves as a state chapter president for the American College of Emergency Physicians. So, he's a busy guy if you couldn't tell from that intro. And in addition to that, he has a really special role and I think he has a special little shout-out that he wants to offer. And then we will get started.

Dr. Bobby Redwood: Thank you, Mia, for that warm introduction. Never too busy for you all and for the opportunity to combat stigma. And one of the best ways to combat stigma is to look at the world with a child's eyes, with a fresh perspective. And I was telling my nine-year-old daughter Frida this morning that I was going to be on a podcast, and she said, sometimes they offer you the chance for a shout-out. Can you send me a shout-out? So, Frida, you are my inspiration. When I combat stigma. I'll try to look at the world through your eyes. Thank you for everything you are, and yeah, I'm just happy to be here today with both of you.

Mia: Awesome. Well, we appreciate Frida sharing some of her dad time with us. So, we're going to start the way we always start on this podcast, which is asking you just to tell us a little bit about your why. So, what is it that's compelling or what makes this important work for you?

Dr. Redwood: Sure. Great question. Without getting too geeky, I am dual trained. Actually, I have a specialty in emergency medicine, which is like what you see on tv, right? We are seeing people overdose on opioids coming in and withdrawal a lot of family anguish. And I'm also trained in preventive medicine. And preventive medicine is the

medical specialty of public health. It's a data residency. It's where you look at big spreadsheets. You look at population level data, whether it's a hospital, a county, a state, the entire nation, the entire world. And I think we all got a little familiar with preventive medicine during the COVID-19 pandemic when we were all looking at graphs and incident rates and all of these things. And the preventive medicine, it can be a little bit dry. You're looking at spreadsheets, we're looking at numbers, but it's not dry for me because I see the real patients first line when I'm working my shifts in the emergency department.

So, when I see someone who comes in blue not breathing and they administer naloxone, and suddenly that person's breathing again and I think, oh my goodness, this life is saved. We have another chance to address this opioid use disorder, to get this person the happy, productive life they deserve the long-term relationships they deserve. That's really powerful and it makes those spreadsheets come to life. And on the same token, when we lose someone, when they stop breathing and we cannot bring them back, and you think, just such a tragedy, another young life lost to this epidemic, you go back to those spreadsheets, and you really dig into it. You say, how can I prevent the next opioid overdose? This is the epidemic of our era. When I speak to my colleagues who trained in the eighties, they talk about HIV and young people dying all around them from HIV.

That's how I feel about the opioid epidemic. And it fires me up. I leave a shift and I want to open my laptop, look at those spreadsheets and say, I'm not just reducing opioid overdoses by point-one-tenth of a percent in X, Y, Z county. I'm saving Mr. Smith or Mr. Jones. I'm really trying to improve society and prolong life. And so that combination has been really powerful and impactful for me. And obviously when we actually talk about changing the world, when we talk about reducing deaths from opioid overdose, stigma is a huge part of that. And that's why I'm so excited to have this platform today with you both.

Mia: Yeah, I mean, it sounds like that perfect storm for you of what you do, what you're sort of up to your elbows in day in and day out, and then the way you've been trained to look at the world and the data and the numbers come together in a way that's really powerful.

Dr. Redwood: It is powerful. I mean, when I went into emergency medicine, I actually was, had a misguided thought that I'd only be treating the patient in front of me. And I actually had a little bit of jealousy for my colleagues in family medicine who really treat the whole family and treat generations of patients. And when I look at substance use disorder, it's a familial disease. This disease has ripple effects across families, across social circles, even generations. I can't tell you how many grandparents I see raising grandkids because the parents are either in the throes of opioid use disorder or deceased. And in emergency medicine, you can sometimes feel it's especially known for burnout. You can sometimes feel like you're immersed in human suffering because let's face it, if you're going to the ER, you're having the worst day of your week, maybe the worst day of your year.

We have a lot of hard conversations in the ED, but it's also very inspiring because we save a lot of lives and we have an opportunity, a powerful opportunity to try to correct the record and get someone back on the right track, get their disease under control. And I think there's few opportunities that are as great as opioid use disorder to get people back on the right track. These are patients who are suffering. They are hungry for meaningful relationships, for financial stability, for housing, for just being able to live a life without cravings and to offer some, some sort of roadmap or resource to get people back on the track they want to be on in life. It's a privileged position to be in and really an amazing work environment.

Brittany: Wow. I get with all of those things so much. My clinical background was in critical care. And so that ER piece, you're exactly right. It's really easy to get burnt out. It's really easy to get maybe jaded or calloused, but to remember the humanity of this is someone's child, this is someone's parent, this is someone, it really brings it back to reality when you are looking at the data. And I agree, it's a driving factor because you literally have seen it with your own eyes. So I agree, it's a huge and impactful piece of this work. I wanted to kind of shift a little bit and ask you really about what some of your projects are or just as an organization, what you're doing and within your field.

Dr. Redwood: Sure. Well, I'll actually piggyback on what you just commented on, and I appreciate you saying that sometimes we get callous. It's so true. It's really hard work in emergency medicine. So I'm the state chapter president for the American College of Emergency Physicians. And first and foremost, I really encourage my colleagues to

address stigma head on and start solving this epidemic. As an ED doc, it's how many people do you have to resuscitate from an overdose before you decide to actually jump in and start preventing this disease and trying to address those upstream factors and the callousness, I think of coping, there's different levels of coping, and one of the easiest ways to cope is make light of things, and we call it gallows humor in the emergency department. And I'm sure you're familiar with that and sometimes you need that. It is what it is.
But I think a higher form of coping is really getting into it and engaging with your patients, engaging with the population, and trying to help, trying to prevent the next one. First of all, I spend a lot of time talking with my emergency physician colleagues about medications for opioid use disorder, about stigma, about alternatives to opioids. Some of that's formalized. I work with the hospital association, the Wisconsin Hospital Association and multiple quality improvement organizations across the states to combat the opioid epidemic. The four strategies that we really employ are decreasing opioid prescriptions. So, trying to clear the medicine cabinets only have opioids in there that are actively being used, use alternatives to opioids in acute care settings. So that's a big part of my work with the emergency physicians is talking about over-the-counter medications, non-pharmaceutical pain modalities, acupuncture, massage, trigger point injections. There are so many options out there that don't involve medications. Harm reduction, like we alluded to earlier. So, naloxone's the big one, but when someone visits an emergency room for opioid overdose, on average, they have seven overdoses in the ER before they die. So, we have on average seven chances to use naloxone and resuscitate someone before that someone isn't alive anymore. And so that's really important to have prescriptions for naloxone, to have naloxone boxes out there to make sure our patients have it in hand and know how to use it. And then the final part of that puzzle is medications for opioid use disorder. And so that's really the formula for beating this epidemic is to get the pills out of the cabinets, suggest alternatives so people never get their first taste of opioids, medicate for opioid use disorder, and then save lives whenever possible. And I would say the fifth part of that is stigma, right? Because all of these things are stigmatized and there's no way that we're going to beat this epidemic that we're going to get people's lives back on track if we don't first address the stigma around treating this disease.

Brittany: No, that's exactly right. I mean, even with your very first intervention you mentioned was I just talked to people about it nail on the head when it comes to coping. It is so much easier to be jovial or to try to make light of a situation instead of a dealing with it head on. But having those real conversations with your peers, with people who value your opinion is really impactful. So as a clinician, I think that truly is a really impactful way to begin the conversation of what can we do to beat this epidemic?

Dr. Redwood: Oh, no, I just love the point that you just made about just talking about it. And there's so many myths even within my profession to be busted. So, I'll give you an example of a project. I'm involved with the Midwest Alternatives to Opioid Project, Midwest Alto Project. It's a tri-state coalition, Illinois, Wisconsin, and Michigan. And the idea is when someone comes in with a painful condition, use an opioid as a last resort. And so if you sprain your ankle, let's not jump to oxycodone, let's talk about ibuprofen, let's talk about Tylenol, let's get some ice on that. Let's wrap it up and get a brace on you. All these things. And when I talk to my fellow emergency physicians, we have a lot of competing interests. So, a lot of people are judged and even paid on their patient satisfaction. And there is a perception that the patient will be unsatisfied if they don't get an opioid prescription, when in fact, when you look at the medical literature, patients are most satisfied when you connect with them as human beings.
Surprise, surprise when you have a nuanced conversation about what their functional goals are about what they've tried for pain already about, honestly, non-opioid therapies, opioids have a lot of side effects. What medications can I offer you that have the fewest side effects? So, as we go about these projects, we create toolkits for hospitals, and we create educational resources. And I give webinars to patient advocate groups and to physicians alike, but we're really trying to get people all on the same page as to have some humanity to approach traumatic injury and acute pain from a logical science-based perspective. And then to have some humility around the really serious side effects of opioids and the reality of opioid use disorder.

Brittany: That was a beautiful answer. Honestly, I loved it because that's it. I mean, the science-based approach to caring for their pain, which there's a lot of new research on ibuprofen and Tylenol being very impactful and effective.

And then moving towards that empathy, that piece of understanding that addiction is just as real of a disease as diabetes or hypertension, cardiac disease, things like that.

Mia: And I just wanted to pick your brain a minute about what your thoughts are. We talked a little bit about Naloxone and as it's sort of moving toward becoming over the counter, how you think that may impact the landscape of rescue medications for opioids?

Dr. Redwood: Oh, great question. Let's talk about stigma with this too. Because there is a medication just like Naloxone out there. You're encouraged to have it in your purse. You're encouraged to have it in your glove box. It will save your life in an instant. And there is zero stigma around it. Epinephrine, the EpiPen anaphylaxis is a life threat that stops you from breathing. Fentanyl on the street is a life threat that stops you from breathing. And they both have an instantaneous cure that's readily available. In fact, naloxone is much more affordable than an EpiPen and oftentimes not covered by insurance what is going on. So that's a big part of my mission is I think of Naloxone as the EpiPen for opioid use disorder. And if we are going to talk about two diseases, why not put 'em on equal footing? They're both fatal. They're both prevalent.

Dr. Redwood: They're out there everywhere. And just like someone can be stung by a bee walking through the woods, someone can with opioid use disorder, who has a craving, think they're getting one tablet and get a different tablet and end up taking the King Kong dose of fentanyl and require naloxone to bring them back to life. And I can't see why a difference exists between these two medications. If we have epinephrine in libraries. So, if someone has anaphylaxis in a library, they can get their EpiPen. We need to have naloxone in libraries. If police know how to administer epinephrine, they need to know how to administer naloxone as well. And there shouldn't be two categories. These are all just medical conditions that we need to help people through. And I do think that naloxone is becoming destigmatized. The FDA had a recent decision to make it available over the counter, which is huge. That is a huge win against stigma in this disease. And I'm excited to see the price come down. I'm excited to see people be able to get it readily, and I'm excited to see it be standard discharge instructions for anytime an opioid is prescribed in the emergency department or other acute care setting. So, there's a lot of work to be done there, but I can just think of so many examples of ways to make this medication more accessible and really reduce the harm from opioid use disorder.

Mia: And this may be the only time I'll ever say this, but I was really excited to start seeing commercials. I've already started seeing commercials for over the counter, they say coming soon over the counter, and at least the commercial I saw was just so beautifully done. It said, accidents happen. This is a lifesaving medication. That's what it said about it. Nothing stigmatizing, nothing. It was so normalizing. I was just like, huh, okay, this is great.

Dr. Redwood: That's incredible. So Mia, I haven't seen those yet. I'm going to have to Google after we get off this podcast. So, I'm excited to see that. I'll share a personal story though. This was before naloxone became over the counter, but you could still, we had standing pharmacist prescription, so anybody could come get it through the pharmacist. And I'm sitting there thinking, I'm an ED doc, I'm driving around, I've seen people have heart attacks in public settings. I need to have naloxone in my glove box. I need to walk the walk and going to that counter. I did. So, I bought the naloxone and I felt seen. I felt like people were looking at me. I felt like, wait a second, I'm a physician. I'm getting naloxone. Is this going to flag on my license somewhere that I might have opioid use disorder? Is that going to affect my livelihood? Is this a smart move? And intellectually, I could overthink all of those things, but my goodness, I really felt it. What our patients feel. I can't imagine actually having opioid use disorder and trying to get that prescription. So, none of us are immune from this stigma.

Mia: Absolutely. Absolutely. And as our listeners can probably tell, we can spend a lot of time chatting with you, and you have a lot of really great things to share, which is why we decided that we want to make this a two-parter. So, for the interest of sort of brevity, we're going to wrap up part one now, and we will have you back shortly, next episode

for our listeners for part two where we will continue this discussion. In the meantime, I want to remind everybody that you can find us wherever you find your favorite podcasts and hit that subscribe button, so you never miss an episode. You'll get notified when we post new episodes, and again, if we love feedback. So, any feedback you have, any ideas you have for who you'd like to hear from or what you'd like to hear on the podcast in the future, please send them to us at stigmapodcast@telligen.com. So, for Brittany and myself, it's been such a pleasure to have Dr. Redwood here, and we'll look forward to the continuation of this conversation.

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