Shine a Light on Stigma Podcast

Transcript - Episode 7: Stigma and Substance Use Disorder - A Conversation with ED Physician Bobby Redwood (Pt.2)

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.

Mia Croyle: Hello and welcome to the stigma podcast. In this podcast, we're talking about ways that stigma impacts people living with substance use disorder and the people who love them. We aim to inspire and empower our listeners to shift away from the culture of stigma toward one that promotes healing and recovery in a supportive and respectful way. I'm Mia, and I'm here with Brittany, and we're back with our guest from the last episode, Dr. Redwood. So, before we jump right back into our great conversation, I just want to remind everybody, if you haven't already listened at least to part one of this conversation, you might want to go back and listen to the episode before this, which is part one of this conversation. And if you haven't listened to all of our episodes before that, we still have a small enough number that it's manageable, but we think there's some really valuable stuff in those previous podcasts.
So, if you're just joining us for the first time now, we invite you to go back and take a listen and then you can find us at your favorite podcast streaming service. We encourage folks to subscribe, not because it helps our numbers in any way. We're not tracking subscribers, but it does help you by getting you a notification every time we post a new podcast. So subscribe and then you won't have to worry about missing any episodes. We welcome and encourage any feedback you have to share stuff you liked, stuff it made you think about stuff you didn't like, or maybe ideas for future episodes that you'd like to see us invite. Guests in particular or topics you'd love to see us cover. You can send any and all of that feedback to our email at stigma podcast@telligen.com.

Mia: With that out of the way, I want to welcome back Dr. Redwood. As a reminder from our last episode, Dr. Redwood is a physician improvement advisor for the Wisconsin Hospital Association, and he has his hand in a lot of projects around opioids, opioid stewardship, medication for opioid use disorder, and reducing stigma around substance use disorder. He's also the physician lead for the Midwest Alternatives to Opioids program, the Wisconsin Dental Pain Protocol, and a Tri-State Coalition to reduce opioid overdoses in long-term care settings. Clinically, he's an emergency medicine physician and he serves as state chapter president for the American College of Emergency Physicians. So welcome back Dr. Redwood.

Dr. Bobby Redwood: It's great to be back. Mia. Hi, Brittany.

Brittany: Hello. Well, that's an impressive resume of sorts. You really are doing all of the things, so I know that you have a lot of experience to offer us. But with that being said, I want to jump right back in. I am really excited to hear what you have to say, just kind of around some examples of stigma that you've actually encountered within your workspace.

Dr. Redwood: Yeah, that's a great question. The last podcast, we talked a lot about the public health aspect of stigma, but I think it's important to get into it. And really, I'll take you within the walls of my hospital today within the walls of the emergency department. And I'll just tell you, stigma is everywhere in medicine, sometimes I think it's like mowing the lawn, it's never going to go away, and we just got to keep mowing and keeping it at bay as new trainees

and new minds come in and they've been kind of influenced by society before they get into medicine. But maybe that's not the case. Maybe we'll truly cure it someday. Let's do it together. But the classic example in the emergency department is the term drug seeker. This label is everywhere, and it is true. It is a fact that someone might come into my ED this shift begging for Dilaudid, literally begging for that medication. But why can't we just say this person suffers from opioid use disorder, they're having intense cravings and it's manifesting as a request for IV opioids.

Dr. Redwood: Why do we have to say drug seeker? I don't call someone with an infection, an antibiotic seeker. And honestly, to be honest, I don, I don't blame the docs and RNs working in the ED necessarily for using these terms. We all have some degree of stress and probably even PTSD from the pain and suffering of working in emergency medicine. It is truly part of our work and on a daily basis we are immersed in a lot of human anguish and one of the coping mechanisms that you'll see is this gala's humor making light of essentially the least funny subjects that there are. And I think that's common. But that being said, I think there's a more mature coping mechanism out there and that's empathy and resilience, a commitment to alleviating human suffering. And that's a higher-level skill. It takes years to develop.

Dr. Redwood: I haven't fully developed it and combating stigma on shift and off is a way that we can actually help our patients and our colleagues move to a better place where substance use disorder is viewed not as some societal ill, but rather a treatable medical condition that really commands our empathy in our professionalism. And sharing that message on shift doesn't always come naturally. Sometimes you feel like you bond with someone, yeah, they're a drug seeker. You don't want to kind of cold shoulder your colleague. And so how do you walk line? How do you set a good example, maybe even politely correct someone if the timing is right, maybe it's after shift, you're grabbing some French fries after shift or something and you're reflecting back on things and you say it sometimes the moment isn't the right time to do it, but that's something that I'm still learning how to do is how to combat stigma on shift.

Brittany: I think it's interesting that you said one of the things you mentioned was on and off shift, and I feel like sometimes I feel like I've started making that shift of being aware of the stigma that I'm even contributing or that gallows humor, but it's kind of like you said, there's a moment where you can kind of pause and maybe even it's as simple as, but it's actually really sad. Maybe it's just that comment of just that shift that you're making within your conversation with your friend you're working with or your colleague of sorts. Because it's subtle. It's subtle. You're acknowledging that yes, this is crazy, what we're seeing is crazy and maybe that humorous part, but then that small shift to, but this is a real person and it's kind of sad. And that could start a conversation where they're like, yeah, it really is.

Brittany: Addiction is hard and real. And so I think it's interesting of trying to find realistic ways to have those conversations with our peers, but those are the ones that are really usually more impactful than a seminar or a webinar telling you to not use that language anymore. But yeah, and I also thought, sorry, I'm kind of shifting back. That was kind of a rabbit trail, but going back to where you mentioned off shift, I feel like I've had that experience with my family, with my grandparents, with my parents, different generations just sitting at the dinner table and maybe something comes up about my work. And I've found that it's harder for me actually with those people to stick to what I truly believe, and it's harder for me to correct them than it almost does with a peer. I don't know if you guys have had that experience, but there's some, I feel like generational stigma too when it comes to this area of healthcare.

Dr. Redwood: I mean spot on Brittany. Absolutely. And that generational stigma, that comment makes me think we have actually made some progress. So, for example, I don't hear the word addict that much anymore. I think that was a big part of the lexicon in the eighties and nineties. And on the other hand, I do hear alcoholic a lot. I still hear that one quite frequently. I don't think we've made as much progress in alcohol use disorder as we have on opioid use disorder. Believe it or not, we're starting to wake up as a specialty in emergency medicine about the merit of person-centered language, which is what you were alluding to there, that there really is a person behind the disease. And when we say garbage like drug seeker or alcoholic or meth head, all we're really doing is conveying to the patient that it's their own moral failing, that they're in our emergency department and that we would prefer they not be here.

Dr. Redwood: I mean, what a way to treat someone who's suffering. It's such a terrible way to spend this precious moment in the patient's journey towards wellness, and it totally poisons that therapeutic relationship that we have. It's a way to burn a bridge early on and not be able to help that person. So, to convey that to your colleagues is, yeah, what's an artful way to do that? I think we know it. I think we all know it intellectually. I think it's rare to find someone who doesn't really get it. And for me it's lead by example, a subtle correction, or I prefer to use this language, and that burns for a moment. But whenever someone's given me peer-to-peer feedback like that in a candidate setting, not in a public setting, not in front of the nurses, not certainly not in front of the patients, but I always do feel a little bit of a burn.

Dr. Redwood: I feel angry at that person for a minute. I got called out and then afterwards I reflect on it and have a lot of respect for 'em. Is the usual kind of mature way to internalize that? Yeah, I mean, how are we going to get better otherwise wise? But in my experience, I've found that a lot of patients when they hear the stigmatizing language, they just leave. They'll leave the ed, they don't have time for that, which I understand and that blows our chance of trying to get them into treatment, trying to start a medication for opioid use disorder. It's really a missed opportunity and they may come back next time as an overdose. So yeah, I have those conversations. I give those nudges and I accept them when they're given to me.

Mia: And I think some of that is just a little bit of a stylistic thing. You have to figure out what works best in your communication, in your normal communication style. For me, I really like to often phrase it as, hey, you know what I learned recently? I didn't know that this word could be interpreted, or this phrase could be hurtful. And I learned it recently and I just wanted to share that with you. Not even as I noticed you're still using this outdated language kind of way. It's just like there was a time I didn't know this and I'm appreciative for the fact that I learned it and I trusting you and I'm trusting your goodness enough to know that you'll also be appreciative to learn this. And that's sort of my approach. But everyone, I really think there are lots of right ways to communicate that, but it is really about trusting our colleagues. If I don't trust that my colleagues want to do better, then I'm not really sure why I'm working with them first of all. But second of all, then I won't offer that correction if I don't think that they care about doing better. Why would I spend the energy? So, it's almost like when I get that correction, I try to remember to view it as, hey, this person believes in me enough that they're going to share more information with me. They know I want to do my best.

Dr. Redwood: I love that, Mia, I'm taking notes. And in the emergency department, you have the people who you know really well, my fellow emergency physicians, my nurses, but you also have a lot of visitors, the ultrasound techs and the radiology techs and the ICU physician comes down. A lot of people you might not interact with so well. So, to be able to code switch a little bit, my one-on-one colleagues where we know all our children's names, we can call each other on our BSS and really just have a frank conversation. But if you have someone coming from a different department, you don't want to lose that moment, that moment to really combat stigma. And that's a great approach to saying, here's something I learned recently. I love that.

Mia: And I love the idea of leadership setting the tone in the emergency department of this is a place that we respect our patients. And all those visitors who are, like you said, in and out, they'll know eventually that that's the reputation of the ed. The ED is they don't tolerate that.

Dr. Redwood: Let me jump on that actually. So I actually am an emergency department administrator as well, and so we think about policies and protocols and all these things, but something that we've done, we actually signed a commitment for the Shine, a Light on stigma campaign and shameless plug here, but this is a pledge that encourages everyone in our ED physician group and other role groups to use person-centered language and to follow our specialty specific policies. Our national chapters have policies on stigma to reduce stigma language in medical encounters. And it's not just for substance use disorder, it's actually for, you might say the cirrhotic guy in bed 18 or the COPD or in bed 19. When you're dealing with a board of patients and you're trying to do your workflow, there's this tendency to drift towards the disease process away from the patient. And the more that we fight that tendency and actually have policies in place that, hey, this isn't who we are, the more our patients are going to pick up on that.

Brittany: Like you just said, this is a safe space. It creates a culture, it's a culture shift. You are setting the tone and then others kind of follow in because they realize, oh, no one else is doing that. Right? And so, by you guys taking that pledge and just educating on it even and then leading by example, it definitely makes a difference.

Dr. Redwood: And you're so right and you're not just showing the culture to our patients. We're showing the culture to ourselves, to our new hires, to everyone in the department. I'll give you an example. You have to be comfortable in emergency medicine, eliciting substance use histories from your patients and asking really important, helpful questions about their substance use. And so, I mean you'll get valuable information by asking patient additional questions about how they manage their condition or what they do in regard to their substance use disorder. You may learn that your patient injects opioids, right? If you don't question that any further, you're going to lose the opportunity to give the patient helpful information, resources, or even discover the true cause of their visit. So, I might ask someone, well, how do you clean your skin to inject? I might be able to prevent abscesses or Hep C or what sites do you use to inject?

Dr. Redwood: Maybe they're using a site that's right next to an artery and I could suggest a harm reduction, a safer site. Do you drawback to confirm that you're in a vessel? Do you have access to sterile needles and syringes? Do you actually use them if you don't use them? How do you clean your supplies? What liquid do you mix with your drug? Being able to ask these questions is you have to have just a really frank open conversation with someone, and you have to drop the stigma. It just can't be there. You're not going to get anywhere in the world of harm reduction or open conversations if that person has a label attached to 'em and they pick up on it. And so I think we started with our oncoming colleagues, but when new colleagues come and see that this is a place where you can just really speak openly, that has ripple effects where we can really get to the heart of the matter and do good medicine.

Brittany: That's exactly it. I mean, you were approachable, right? By asking those questions, you're saying, I want to know these things about you. And that's once again, treating that patient as a true holistic approach to that patient that these are things that are real in their life. If they are utilizing or using IV, injecting for their opioids, then these are things we need to talk about. And so, they're probably not going to bring them up on their own, as you mentioned. And so it's super important for us as the people on the other side to be willing to ask those questions and to listen.

Dr. Redwood: Yeah, we can ask someone if they put a cream or an ointment on their poison ivy, why can't we ask 'em what gauge of needle they use to inject their heroin? Let's get into it. Exactly.

Mia: Yeah. I was watching a TED Talk the other day and the person said, this is probably a slight misquote, but she said she was talking about harm reduction, and she was saying, the people I work with, I want them to know that I don't care that they drugs, but I care a heck of a lot that they use clean needles and that they use a safe injection site and that they have the supplies that they need. I think for me, that just stuck with me because it was like, yeah, if we could be as focused on those things as people seem to get really hung up about, but they use drugs, it's like, yep, okay. And then now. So, I love that sort of way to just have that conversation in a really caring, empathetic way. This is how you are managing this. Let's see if we can't manage it in a slightly healthier way.

Dr. Redwood: Absolutely. I love that.

Mia: And it makes me think about our previous guest Drew from Shred the Stigma was talking about how do we help people shift from chaotic substance use disorder to something a little more safe, healthy, and manageable for them? And how that's a first step in building that trust with them.

Brittany: And it's hard to view it that way, but it truly is a spectrum. We can have really chaotic drug use that's dangerous and kind of out of control. That's poor language probably. And then that shift when they start having clean supplies and then maybe they are getting that infection cared for, and then maybe they can back away from their use just a little bit and it's a little bit more manageable. And then maybe they're in touch with the case manager in the ER

when they came in and got that infection treated. And it's these subtle things. And that's a conversation I was even having with my husband when I used the term less chaotic drug use. He was like, what does that even mean? How can you of less chaotic drug use? But that was the conversation we had and really truly being a spectrum of where are we at on that and where can we support them to get them to move just one step closer to the other side of this drug use and supporting them is really how we're going to do that. But Dr. Redwood, you've given us lots of examples actually just throughout this on different things that we can do practically to improve our own stigma, our own daily life as we're working with patients. And I was going to see if you had anything else that you thought would be helpful that our listeners could take away just in their professional life as well as their personal as we're closing up today?

Dr. Redwood: No, absolutely. I mean, honestly, I know it's basic, but I would start with a primer on person-centered language and more than that, an encouragement to actually use it on your next shift. I like to give concrete things. So next shift you go and try to use that person centered language. But patients are not just their disease, they are unique individuals. They have experiences that shape who they are. And we use the example of a non-substance abuse disorder patient. Would we refer to them as a sickler or schizophrenic? I think that's falling to the wayside and broadly in medicine. But if we do that, you reduce a person to just one aspect of their life. And quite honestly, these terms are often used in a derogatory fashion. So how do we move past that? I break it into categories. The first is substance use disorder or addiction. So, we want to say substance use disorder. We want to move away from that non-person-centered language and talk about this as a disease. And then when you talk about the patient themselves, they're a person with substance use disorder. It's important to hear it out loud. This is how you say it.

Dr. Redwood: When a child is born and the mother used opioids, that's a baby with opioid dependency. And then a lot of it is about recovery. So, we don't want to use your clean or fall off the wagon or any of those terms that kind of really nail it to the person. They're a person in recovery. They're a person who's not taking drugs or drinking. They're a person who's abstinent. And then around treatment, it's treatment for medication or addiction or medication for opioid use disorder, medication for alcohol use disorder, et cetera. And then we talk about a positive toxicology result or a negative toxicology result instead of a clean or dirty catch. Those are the ones that really come up frequently in my specialty. And it doesn't take long to switch there. If you start with the idea of it's a person and that this is a medical disease, the rest kind of follows. You'll find it actually sounds funny when you say it the wrong way or when you use stigmatizing language, it doesn't roll off the tongue in the same way. But that would be my suggestion for everyone out there is just when you go on shift next, try saying it. Try saying substance use disorder. Try saying opioid use disorder, see if it rolls off the tongue. Get your motor memory intact and your colleagues will certainly pick up on it and hopefully follow your example.

Mia: And those are great examples. And I love that little sort of progression that you offered. I think that really helps it not just be some words I have to memorize, but it's really the conceptual framework behind why we use those words and how they are all connected. There's a thread through all of that. And if you're looking for some resources, some more tangible resources, Brittany's organization Telligen has a really great badge card that just lists some of that language on it that you could get and put right on your badge. And if you're interested in the resources that are available through that Shine a Light on Stigma campaign that Dr. Redwood mentioned, there is a pledge that you can sign, and you can invite others in your organization to sign it. There's an organizational level pledge you could also take. And then there are some resources specifically around this person-centered language. So, some learning, you could do some tools to do that. And you can find Brittany's information from Telligen at where Brittany?

Brittany: At telligenqiconnect.com. It's a lot of words, but the QI is that quality improvement. So telligenqiconnect.com is where you'll be able to find that badge reel and also just links to these different things that we're referring to. And Mia, do you want to give yours?

Mia: Sure. So, the Shine a Light on Stigma campaign is a project through Superior Health Quality Alliance. I can give you the website, but it's a little long. Probably your best bet is to pull up your favorite search engine, Google, Bing, whatever else you might use, and type in Superior Health and Shine a Light on Stigma. And it will take you right there. And that's like I said, through the Superior Health Quality Alliance, and there's a bunch of resources there.

You have a bunch of resources. I think Dr. Redwood's call to action in terms of, Hey, you're in your next shift. Try and use something off this list. Try and use that person-centered language. I think it's an easy way you can think about it for a long time without jumping in and getting your feet wet. But if you just say, hey, I'm going to try this. I'm going to give it a go at my next shift. Next time I'm working with patients or in a meeting internally, some people listening may not be in direct care positions, and these are things you can use in a conversation with a colleague in a meeting, other things as well. So everywhere that we can spread this language, I think helps that sort of tidal wave of culture change that we're hoping to generate.

Brittany: Exactly. Yeah. So, it starts with us. It starts with us taking one right step in the right direction to create a larger shift within our organizations as well as our states and our world. So, thank you for committing to that. Just by listening to this podcast. You're really showing us that as well as yourself, that you're taking this seriously and that you value that this work. So, we just wanted to thank you for joining us, and thank you, **Dr. Redwood**, for all of your golden nuggets of advice. It's been great to have such a fun speaker on to learn from

Dr. Redwood: An honor and a privilege. Have me back in the future. I love chatting with you both.
Mia: All right, and as always, just a reminder, any comments, questions, cheers or cheers or ideas and suggestions for future episodes, send them to us at stigmapodcast@telligen.com. Thanks for listening and we'll talk with you next time.

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