Stigma and Science: Updates in the Care of SUD in the Perinatal Period

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Disclosures

- None

Language

- Principle 1: Person-Centered
  - Example - People who use drugs, people in recovery, people with addiction
- Principle 2: Evidence-Based
  - Example - Substance Use Disorder or Addiction
- Principle 3: Gender-Inclusive
  - Not everyone with the capacity for pregnancy identifies as a woman, and not every woman has the capacity for pregnancy
- Principle 4: Social Needs-Informed or Needs-Targeted
  - Not Social Determinants of Health

Trust

- Trust is an attitude that we have towards people whom we hope will be trustworthy (where trustworthiness is a property not an attitude)
- The trustor must accept some degree of vulnerability or risk
- Trust: Hard to Achieve, Easy to Loose

Trust is an Essential Component of Healthcare

AMA

Patient-Physician Relationships

Code of Medical Ethics Opinion 1.1.1

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

Mistrust

Provider

- Mistrust (often) misplaced
- Rooted in discrimination and prejudice
- Mistrust can be overcome

Patient

- Mistrust warranted by people who experience oppression
- Mistrust involves “action-tendencies” of avoidance or withdrawal (D’Cruz, 2019)

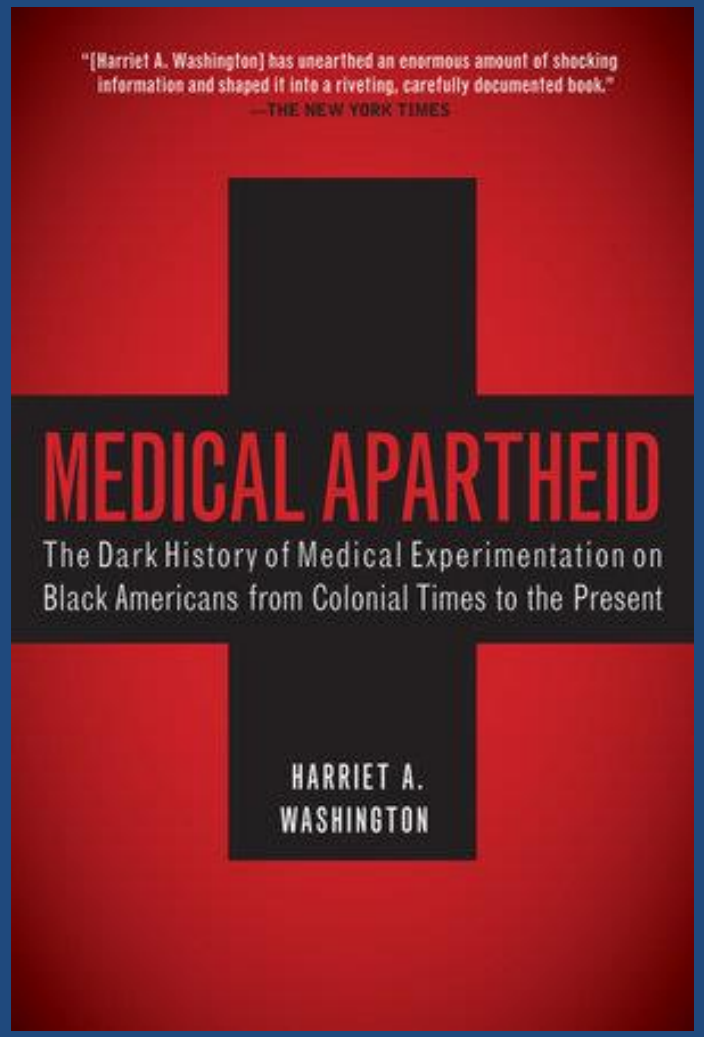
Power Differential

Risk/vulnerability is different for patients than providers

The “Trust Gap” in Medicine

- In 1966, 73% of US citizens had “great confidence” in the medical profession; in 2012, only 34% did
- In 1975, 80% expressed a “great deal” or “quite a lot” of confidence in the medical system; by 2015, 37% did (Commonwealth Fund, 2021)
- Social and economic inequalities shape and sustain mistrust (particularly among populations that experience health inequities) (Jaiswal 2019)

Medical Mistrust:
Historic Trauma and Cultural Memory



Medical Mistrust:
Emerges from Experiences of Discrimination

Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults

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ABSTRACT

PURPOSE Although we know that racial and ethnic minorities are more likely to have mistrust in the health care system, very limited knowledge exists on correlates of such medical mistrust among this population. In this study, we explored correlates of medical mistrust in a representative sample of adults.

METHODS We analyzed cross-sectional study data from the Survey of California Adults on Serious Illness and End-of-Life 2019. We ascertained race/ethnicity, health status, perceived discrimination, demographics, socioeconomic factors, and medical mistrust. For data analysis, we used multinomial logistic regression models.

RESULTS Analyses were based on 704 non-Hispanic Black adults, 711 Hispanic adults, and 913 non-Hispanic White adults. Racial/ethnic background was significantly associated with the level of medical mistrust. Adjusting for all covariates, odds of reporting medical mistrust were 73% higher (adjusted odds ratio [aOR] = 1.73; 95% CI, 1.15-2.61, P <.01) and 49% higher (aOR = 1.49; 95% CI, 1.02-2.17, P <.05) for non-Hispanic Black and Hispanic adults when compared with non-Hispanic White adults, respectively. Perceived discrimination was also associated with higher odds of medical mistrust. Indicating perceived discrimination due to income and insurance was associated with 98% higher odds of medical mistrust (aOR = 1.98; 95% CI, 1.71-2.29, P <.001). Similarly, the experience of discrimination due to racial/ethnic background and language was associated with a 25% increase in the odds of medical mistrust (aOR = 1.25; 95% CI, 1.10-1.43; P <.001).

CONCLUSIONS Perceived discrimination is correlated with medical mistrust. If this association is causal, that is, if perceived discrimination causes medical mistrust, then decreasing such discrimination may improve trust in medical clinicians and reduce disparities in health outcomes. Addressing discrimination in health care settings is appropriate for many reasons related to social justice. More longitudinal research is needed to understand how complex societal, economic, psychological, and historical factors contribute to medical mistrust. This type of research may in turn inform the design of multilevel community- and theory-based training models to increase the structural competency of health care clinicians so as to reduce medical mistrust.

Ann Fam Med 2021;19:4-15. https://doi.org/10.1370/afm.2632.

Table 4. Multivariate Associations Between Participant Characteristics and Trust (N = 2,257)

	Level of Trust[a]			
	A Lot		Some	
Characteristic	aOR (95% CI)	*P* Value	aOR (95% CI)	*P* Value
Sex				
Male	1.09 (0.79-1.50)	.59	1.41 (1.04-1.90)	<.05
Female (ref)	1.00	...	1.00	...
Age, per year	0.97 (0.96-0.98)	<.001	0.99 (0.98-1.00)	.10
Educational attainment, y	0.98 (0.90-1.07)	.66	1.02 (0.95-1.11)	.57
Household Income				
<150% FPL	1.03 (0.66-1.60)	.90	1.30 (0.85-1.98)	.23
150%-399% FPL	1.09 (0.76-1.55)	.64	1.36 (0.98-1.90)	.07
≥400% FPL (ref)	1.00	...	1.00	...
Race/ethnicity				
Non-Hispanic Black	1.73 (1.15-2.61)	<.01	1.32 (0.89-1.95)	.17
Hispanic	1.49 (1.02-2.17)	<.05	1.29 (0.91-1.82)	.15
Non-Hispanic White (ref)	1.00	...	1.00	...
Primary care provider				
No	7.56 (5.06-11.30)	<.000	2.76 (2.01-3.78)	<.001
Yes (ref)	1.00	...	1.00	...
Self-rated health[b]	1.68 (1.43-1.98)	<.001	1.39 (1.20-1.62)	<.001
Perceived discrimination due to income and type of or lack of insurance	1.98 (1.71-2.29)	<.001	1.41 (1.24-1.59)	<.001
Perceived racial or language-related discrimination	1.25 (1.10-1.43)	<.001	1.19 (1.06-1.33)	<.003

Medical Mistrust:
Discrimination and Perceptions of Addiction Treatment

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Experiences of racial discrimination in the medical setting and associations with medical mistrust and expectations of care among black patients seeking addiction treatment

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Keywords:
Racial discrimination
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Healthcare disparities
Medical mistrust
Substance use treatment
Social justice

ABSTRACT

Introduction: Experiences of racial discrimination in the medical setting are common among Black patients and may be linked to mistrust in medical recommendations and poorer clinical outcomes. However, little is known about the prevalence of experiences of racial mistreatment by healthcare workers among Black patients seeking addiction treatment, or how these experiences might influence Black patients' medical mistrust or expectations of care.

Methods: Participants were 143 Black adults recruited consecutively from two university addiction treatment facilities in Columbus, Ohio. All participants completed validated surveys assessing perceptions of prior racial discrimination in the medical setting and group-based medical mistrust. Participants were also asked a series of questions about their expectations of care with regard to racial discrimination and addiction treatment. Descriptive analyses were used to characterize the sample with regard to demographics, perceived racial discrimination and medical mistrust. Kendall tau-b correlations assessed relationships between racial discrimination, mistrust and expectations of care.

Results: Seventy-nine percent (n = 113) of participants reported prior experiences of racial discrimination during healthcare. Racial discrimination in the medical setting was associated with greater mistrust in the medical system and worse expectations regarding racial discrimination in addiction treatment including delays in care-seeking due to concern for discrimination, projected non-adherence and fears of discrimination-precipitated relapse.

Conclusions: Black patients seeking addiction treatment commonly report experiencing racial discrimination by healthcare workers which may be associated with mistrust in the medical system and expectations of care. Strategies to eliminate and mitigate experiences of racial discrimination may improve addiction treatment receptivity and engagement.

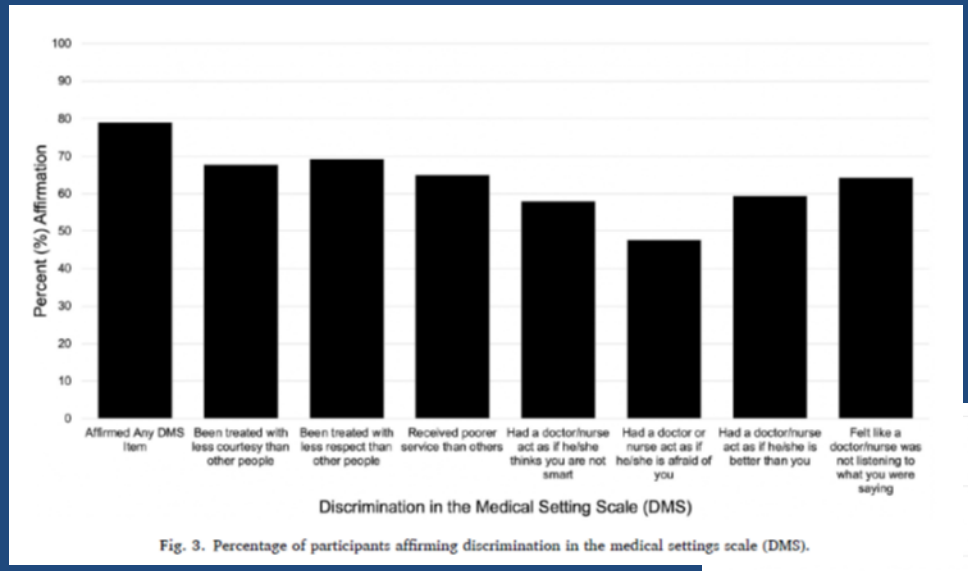


Fig. 3. Percentage of participants affirming discrimination in the medical settings scale (DMS).

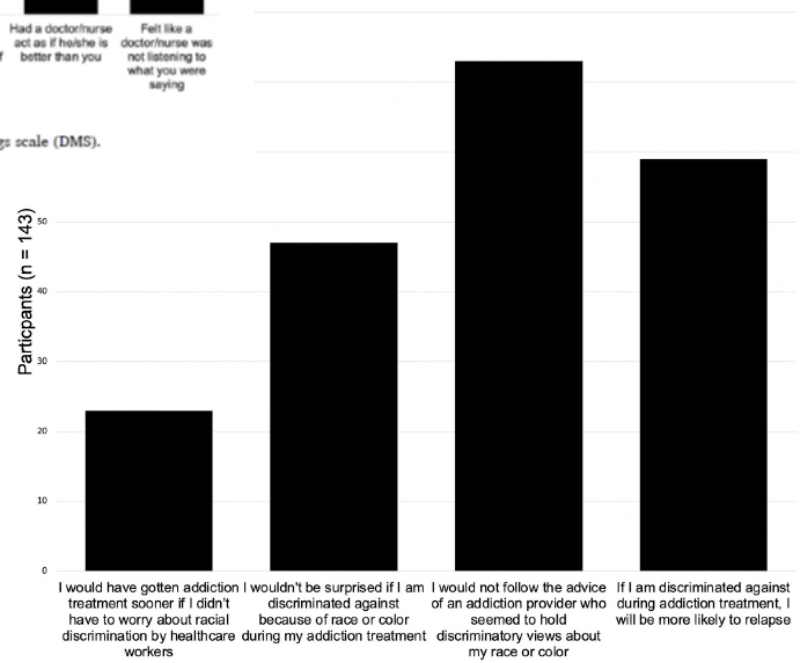


Fig. 2. Participant Affirmations of discrimination-based negative expectations of addiction treatment.

Conceptual Model

Group-based Medical Mistrust

Experience of Healthcare Discrimination

Expectations of Care and Health Outcomes

Historic Trauma
Everyday Racism

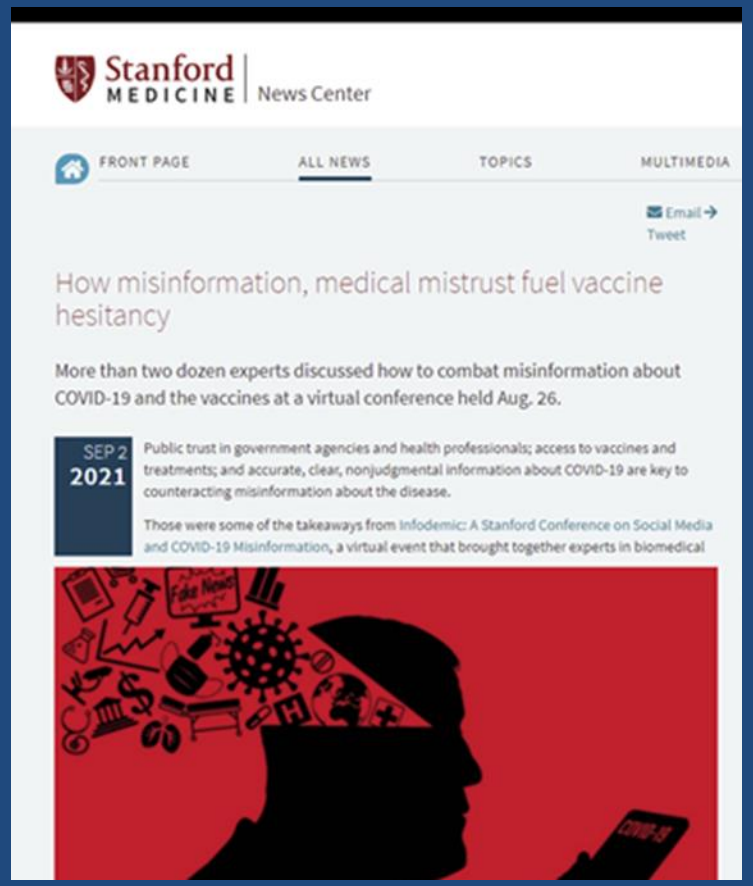
Structural Inequities

Clinical Care

Implicit and Explicit Bias

after Hall JSAT 2021

Medical Mistrust:
NOT Conspiracy Theory, NOT Misinformation



"Even the term mistrust is victim blaming. It puts it on the community when in fact the community has been let down by the medical system and by providers who continue to discriminate."

Kimlin Tam Ashing, PhD

Addiction Medicine: Mutual Mistrust

Mutual Mistrust in the Medical Care of Drug Users

The Keys to the "Narc" Cabinet

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OBJECTIVE: **Caring for patients who are active drug users is challenging. To better understand the often difficult relationships between illicit drug–using patients and their physicians, we sought to identify major issues that emerge during their interactions in a teaching hospital.**

DESIGN: **Exploratory qualitative analysis of data from direct observation of patient care interactions and interviews with drug-using patients and their physicians.**

SETTING: **The inpatient internal medicine service of an urban public teaching hospital.**

PARTICIPANTS: **Nineteen patients with recent active drug use, primarily opiate use, and their 8 physician teams.**

RESULTS: **Four major themes emerged. First, physicians feared being deceived by drug-using patients. In particular, they questioned whether patients' requests for opiates to treat pain or withdrawal might result from addictive behavior rather than from "medically indicated" need. Second, they lacked a standard approach to commonly encountered clinical issues, especially the assessment and treatment of pain and opiate withdrawal. Because patients' subjective report of symptoms is suspect, physicians struggled to find criteria for appropriate opiate prescription. Third, physicians avoided engaging patients regarding key complaints, and expressed discomfort and uncertainty in their approach to these patients. Fourth, drug-using patients were sensitive to the possibility of poor medical care, often interpreting physician inconsistency or hospital inefficiency as signs of intentional mistreatment.**

CONCLUSION: **Physicians and drug-using patients in the teaching hospital setting display mutual mistrust, especially concerning opiate prescription. Physicians' fear of deception, inconsistency and avoidance interacts with patients' concern that they are mistreated and stigmatized. Medical education should focus greater attention on addiction medicine and pain management.**

KEY WORDS: **injection drug use; physician-patient relations; attitude of health personnel; trust; pain treatment; ethnography.**
J GEN INTERN MED 2002;17:327–333.

There is a great deal of antagonism set up, because the doctors are the ones with the keys to the "narc" cabinet... and the patients are the ones who need and want the narcotics, both for real and objectifiable and unobjectifiable reasons, and that puts all the doctors in a difficult position.—Senior Medical Resident

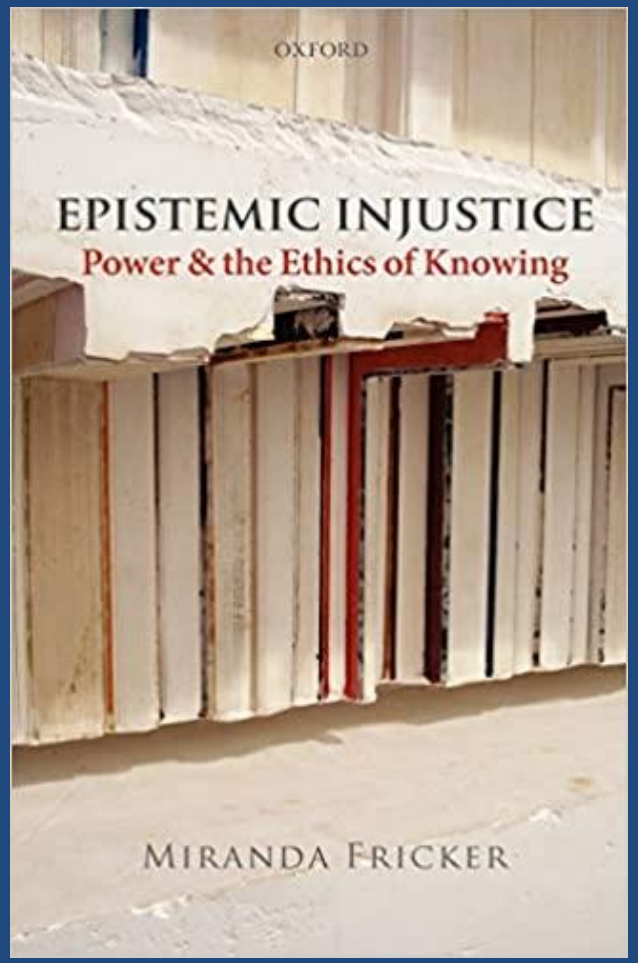
When patients who are actively using illicit drugs are admitted to the hospital, physicians in teaching hospitals confront some of their most challenging work.[1] Addressing the dangers of an acute illness while giving appropriate consideration to the addiction that has often led to hospitalization can be complex. Patients may not be ready for addiction treatment, and even if they are, access to such treatment is limited.[2,3] Acute and chronic psychosocial issues can manifest as behavioral problems[1] that, coupled with the stresses of medical training, may be frustrating for physicians and staff.

Historically, physicians have been excluded from a major role in the treatment of opiate addiction.[4–6] The Harrison Act of 1914 and the subsequent prosecution of physicians who maintained opiate addicts in a medical setting provided stark incentives to avoid treating addiction problems.[5–8] Under current law, physicians may treat opiate withdrawal symptoms in addicted patients who are hospitalized for medical conditions other than addiction. Further addiction treatment, including methadone maintenance, is strictly regulated, requiring special state and federal registration.[9] This isolation of addiction treatment

When the patient is always seeking, there is a sort of a tone, always complaining and always trying to get more. It's that seeking behavior that puts you off, regardless of what's going on, it just puts you off.—Junior Medical Resident

I can tell they are playing games by their intonation, their voice, their body language. They are saying, "I will talk the way you want to get the drugs I need." It's all veiled in a whole body language to get the drug. Being ill is secondary.—Junior Medical Resident

The Capacity to Know: Challenged



- Testimonial Injustice – occurs when there is a “credibility deficit”
  - Patient may be telling the trust, but we deflate the level of credibility and thereby undermine the person as a giver of knowledge
  - Provider is wronged as well – in their capacity as a knower

Epistemic Injustice and Scientific Racism

Pain Medicine

Pain Medicine 2012; 13: 150–174
Wiley Periodicals, Inc.

REVIEW ARTICLE

Time to Take Stock: A Meta-Analysis and Systematic Review of Analgesic Treatment Disparities for Pain in the United States

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Abstract

Background. The recent Institute of Medicine Report assessing the state of pain care in the United States acknowledged the lack of consistent data to describe the nature and magnitude of unrelieved pain and identify subpopulations with disproportionate burdens.

Objectives. We synthesized 20 years of cumulative evidence on racial/ethnic disparities in analgesic treatment for pain in the United States. Evidence was examined for the 1) magnitude of association between race/ethnicity and analgesic treatment; 2) subgroups at an increased risk; and 3) the effect of moderators (pain type, setting, study quality, and data collection period) on this association.

Methods. United States studies with at least one explicit aim or analysis comparing analgesic treatment for pain between Whites and a minority group were included (SciVerse Scopus database, 1989–2011).

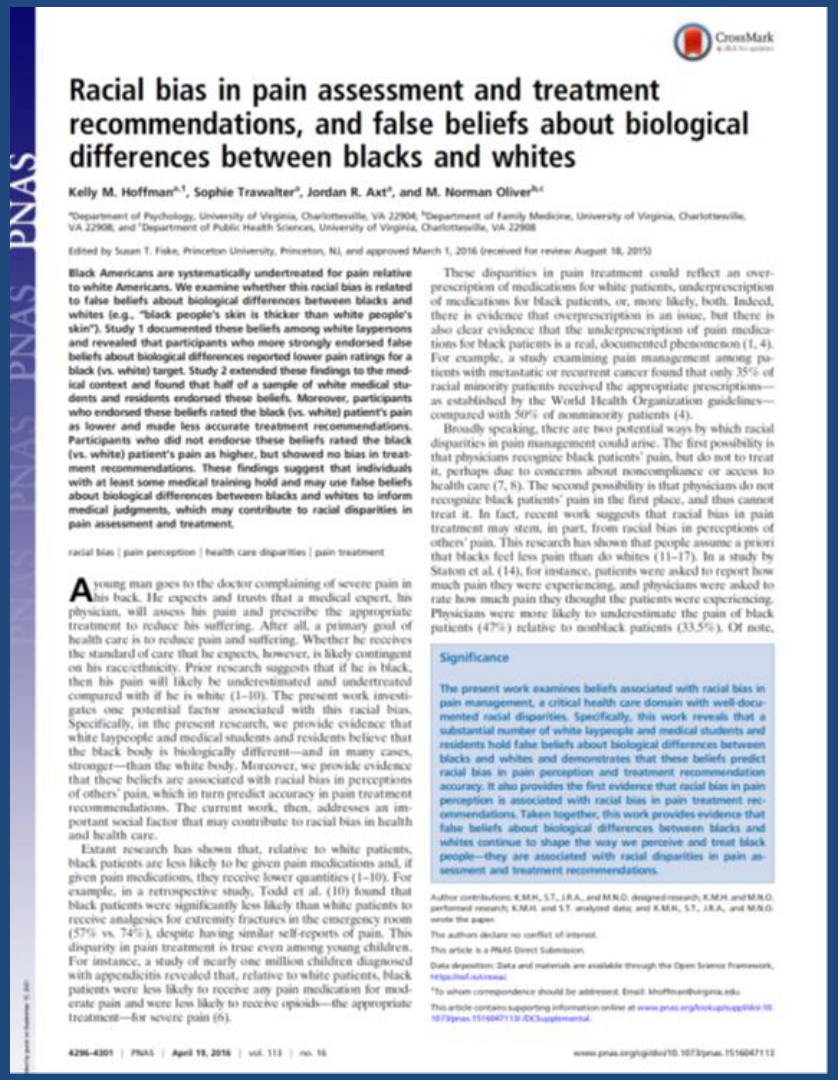
Results. Blacks/African Americans experienced both a higher number and magnitude of disparities than any other group in the analyses. Opioid treatment disparities were ameliorated for Hispanics/Latinos for "traumatic/surgical" pain ($P = 0.293$) but remained for "non-traumatic/nonsurgical" pain (odds ratio [OR] = 0.70, 95% confidence interval [CI] = 0.64–0.77, $P = 0.000$). For Blacks/African Americans, opioid prescription disparities were present for *both* types of pain and were starker for "non-traumatic/nonsurgical" pain (OR = 0.66, 95% CI = 0.59–0.75, $P = 0.000$). In subanalyses, opioid treatment disparities for Blacks/African Americans remained consistent across pain types, settings, study quality, and data collection periods.

Conclusion. Our study quantifies the magnitude of analgesic treatment disparities in subgroups of minorities. The size of the difference was sufficiently large to raise not only normative but quality and safety concerns. The treatment gap does not appear to be closing with time or existing policy initiatives. A concerted strategy is needed to reduce pain care disparities within the larger quality of care initiatives.

Key Words. Pain; Disparities—Ethnic; Disparities—Racial; Pain Management; Pain Treatment; Opioids; Analgesics; The Joint Commission; United States

Introduction

The enormity of unrelieved pain and its associated economic burden constitutes a pain crisis in America. The annual cost of pain in the United States is estimated at $635 billion in direct medical expenditures and indirect costs related to lost productivity [1]. Despite high profile pain-related clinical research and policy initiatives in the last decade [2–4], many deficits remain in pain care in the United States. Recent efforts, authorized as part of the Patient Protection and Affordable Care Act (ACA) [5], renew national commitment to this protracted public health problem. A deliverable in this direction is the recently released Institute of Medicine (IOM) Report [1] that assessed the state of science regarding pain care in America. This report acknowledged the lack of consistent data with which to describe the nature and magnitude of the problem of unrelieved pain, and identified



PNAS PNAS PNAS

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

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Black Americans are systematically undertreated for pain relative to white Americans. We examine whether this racial bias is related to false beliefs about biological differences between blacks and whites (e.g., "black people's skin is thicker than white people's skin"). Study 1 documented these beliefs among white laypersons and revealed that participants who more strongly endorsed false beliefs about biological differences reported lower pain ratings for a black (vs. white) target. Study 2 extended these findings to the medical context and found that half of a sample of white medical students and residents endorsed these beliefs. Moreover, participants who endorsed these beliefs rated the black (vs. white) patient's pain as lower and made less accurate treatment recommendations. Participants who did not endorse these beliefs rated the black (vs. white) patient's pain as higher, but showed no bias in treatment recommendations. These findings suggest that individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment.

racial bias | pain perception | health care disparities | pain treatment

A young man goes to the doctor complaining of severe pain in his back. He expects and trusts that a medical expert, his physician, will assess his pain and prescribe the appropriate treatment to reduce his suffering. After all, a primary goal of health care is to reduce pain and suffering. Whether he receives the standard of care that he expects, however, is likely contingent on his race/ethnicity. Prior research suggests that if he is black, then his pain will likely be underestimated and undertreated compared with if he is white (1–10). The present work investigates one potential factor associated with this racial bias. Specifically, in the present research, we provide evidence that white laypeople and medical students and residents believe that the black body is biologically different—and in many cases, stronger—than the white body. Moreover, we provide evidence that these beliefs are associated with racial bias in perceptions of others' pain, which in turn predict accuracy in pain treatment recommendations. The current work, then, addresses an important social factor that may contribute to racial bias in health and health care.

Extant research has shown that, relative to white patients, black patients are less likely to be given pain medications and, if given pain medications, they receive lower quantities (1–10). For example, in a retrospective study, Todd et al. (10) found that black patients were significantly less likely than white patients to receive analgesics for extremity fractures in the emergency room (57% vs. 74%), despite having similar self-reports of pain. This disparity in pain treatment is true even among young children. For instance, a study of nearly one million children diagnosed with appendicitis revealed that, relative to white patients, black patients were less likely to receive any pain medication for moderate pain and were less likely to receive opioids—the appropriate treatment—for severe pain (6).

These disparities in pain treatment could reflect an overprescription of medications for white patients, underprescription of medications for black patients, or, more likely, both. Indeed, there is evidence that overprescription is an issue, but there is also clear evidence that the underprescription of pain medications for black patients is a real, documented phenomenon (1, 4). For example, a study examining pain management among patients with metastatic or recurrent cancer found that only 35% of racial minority patients received the appropriate prescriptions—as established by the World Health Organization guidelines—compared with 50% of nonminority patients (4).

Broadly speaking, there are two potential ways by which racial disparities in pain management could arise. The first possibility is that physicians recognize black patients' pain, but do not to treat it, perhaps due to concerns about noncompliance or access to health care (7, 8). The second possibility is that physicians do not recognize black patients' pain in the first place, and thus cannot treat it. In fact, recent work suggests that racial bias in pain treatment may stem, in part, from racial bias in perceptions of others' pain. This research has shown that people assume a priori that blacks feel less pain than do whites (11–17). In a study by Staton et al. (14), for instance, patients were asked to report how much pain they were experiencing, and physicians were asked to rate how much pain they thought the patients were experiencing. Physicians were more likely to underestimate the pain of black patients (47%) relative to nonblack patients (33.5%). Of note,

Significance

The present work examines beliefs associated with racial bias in pain management, a critical health care domain with well-documented racial disparities. Specifically, this work reveals that a substantial number of white laypeople and medical students and residents hold false beliefs about biological differences between blacks and whites and demonstrates that these beliefs predict racial bias in pain perception and treatment recommendation accuracy. It also provides the first evidence that racial bias in pain perception is associated with racial bias in pain treatment recommendations. Taken together, this work provides evidence that false beliefs about biological differences between blacks and whites continue to shape the way we perceive and treat black people—they are associated with racial disparities in pain assessment and treatment recommendations.

Author contributions: K.M.H., S.T., J.R.A., and M.N.O. designed research; K.M.H. and M.N.O. performed research; K.M.H. and S.T. analyzed data; and K.M.H., S.T., J.R.A., and M.N.O. wrote the paper.

The authors declare no conflict of interest.

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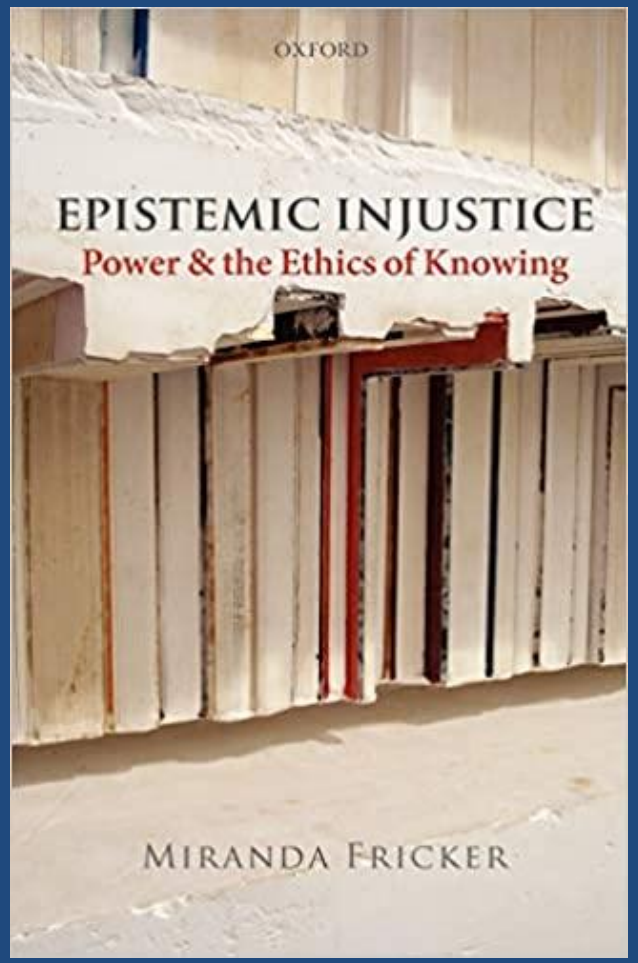
The Capacity to Interpret: Challenged



- Hermeneutical Injustice occurs when an individual's social experience is obscured from collective understanding
- Not the result of individual but structural prejudice
- Results from inequality, marginalization, "asymmetric cognitive disadvantage"
- People who experience prejudice may have difficulty articulating their experiences

Conceptual Model

Hermeneutical Injustice

Group-based Medical Mistrust

Historic Trauma
Everyday Racism

Structural Inequities

Testimonial Injustice

Experience of Healthcare Discrimination

Clinical Care

Implicit and Explicit Bias

Expectations of Care and Health Outcomes

after Hall JSAT 2021

Most People Use Drugs but Only Some Develop Addiction

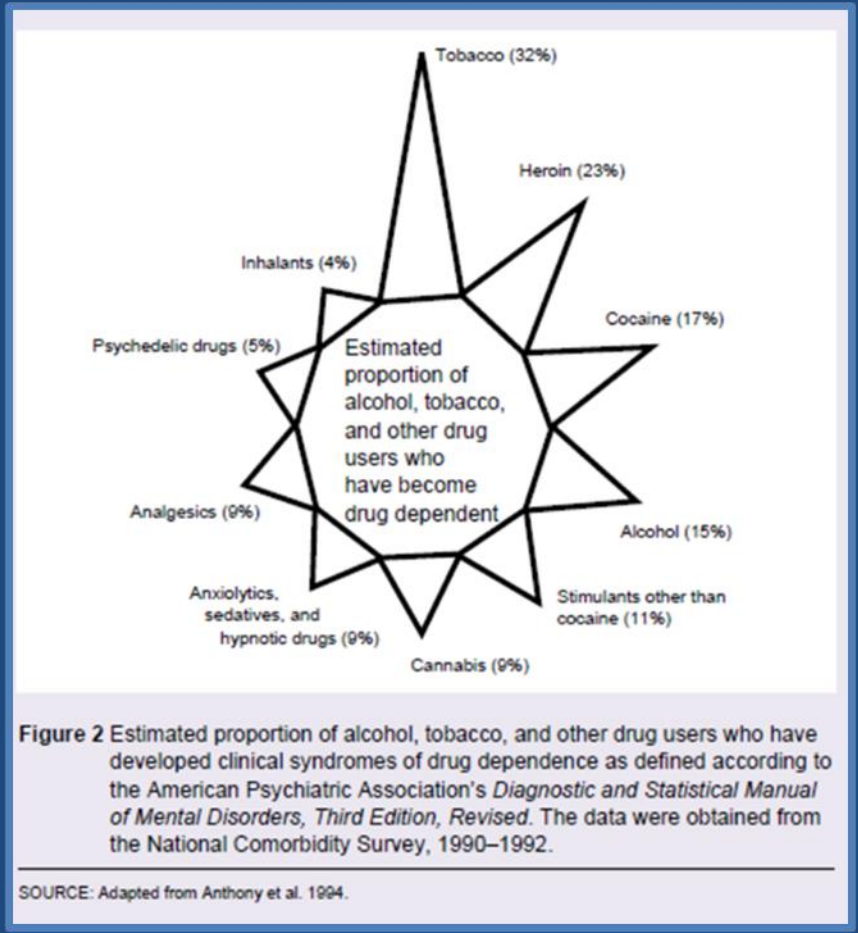
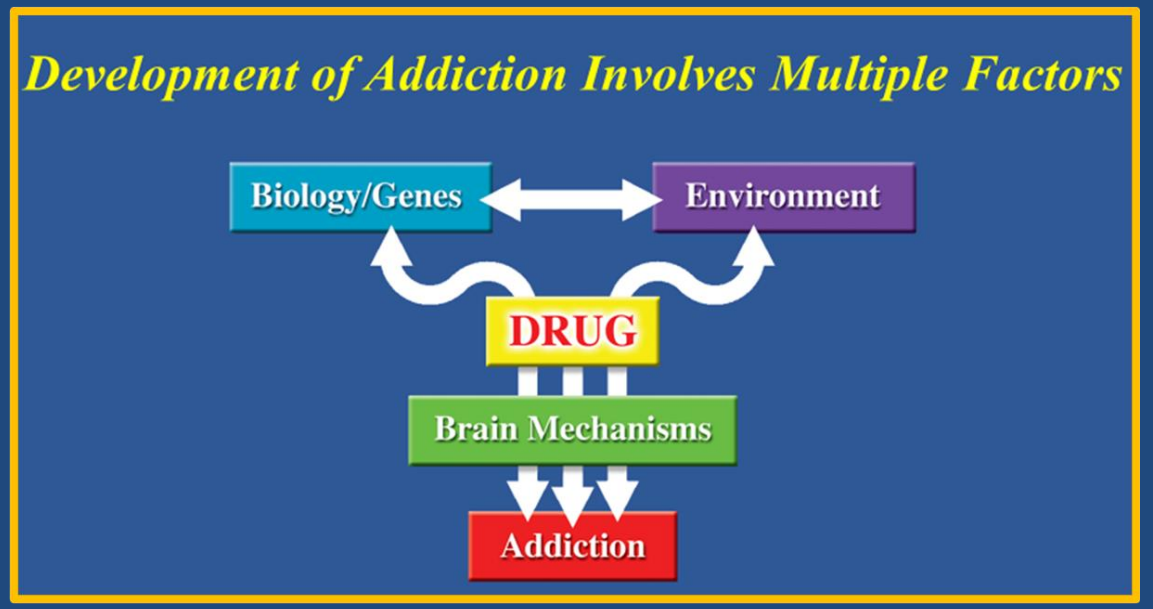


Figure 2 Estimated proportion of alcohol, tobacco, and other drug users who have developed clinical syndromes of drug dependence as defined according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. The data were obtained from the National Comorbidity Survey, 1990–1992.

SOURCE: Adapted from Anthony et al. 1994.



Use Is Not Use Disorder

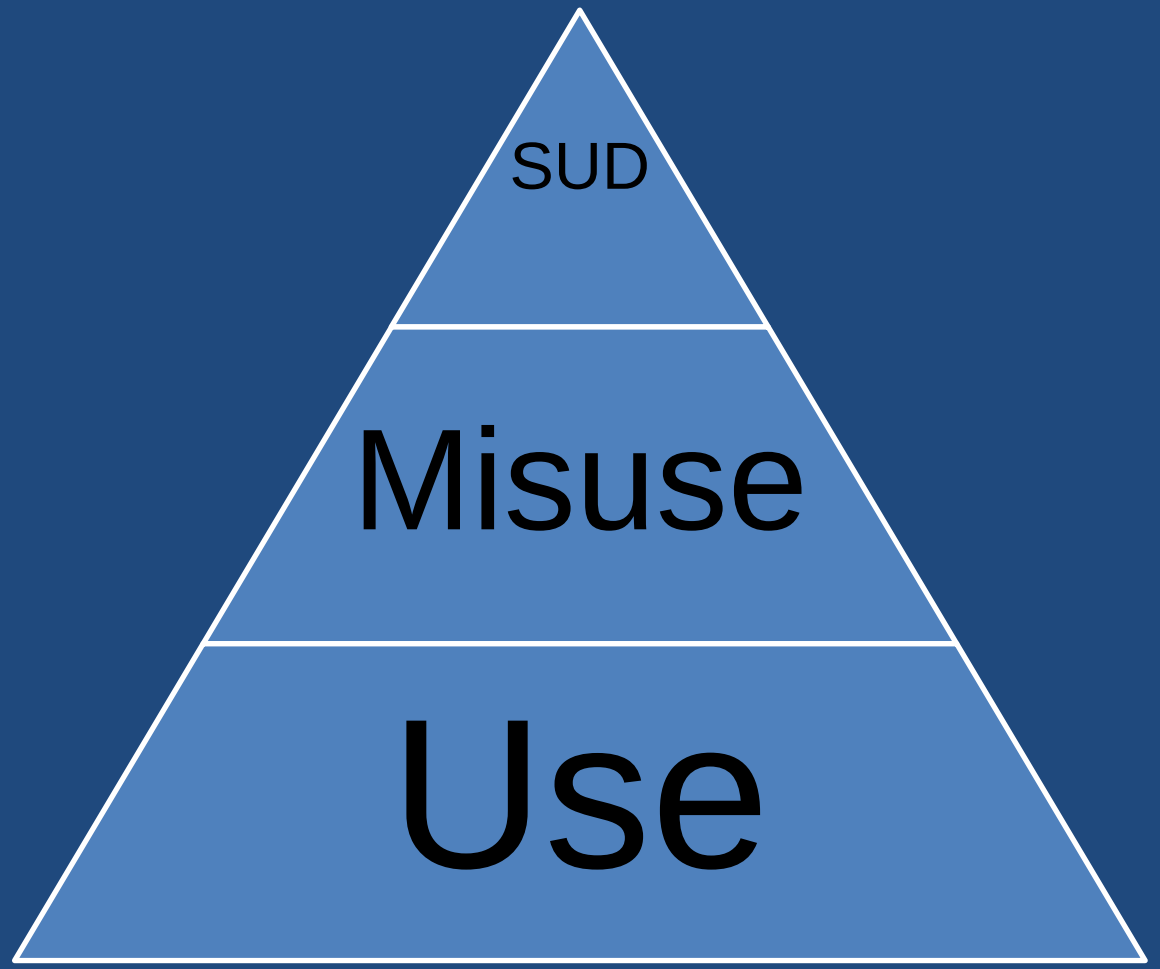
- Universal Screening/Assessment
- “Can I ask you some questions about drinking, smoking, and other drugs?”
  - Screening can be declined (right of refusal)
  - Establishing trust requires trusting and time

Use Is Not Use Disorder

Addiction – Treatment

Misuse – Brief Intervention

Use – Education (?)



DSM-5 Substance Use Disorders[1]

1. Tolerance[2]

2. Withdrawal[2]

Loss of Control

5. Increased time spent obtaining, using or recovering

6. Craving/Compulsion

Use Despite Negative Consequences

7. Role failure, work, home, school

8. Social, interpersonal problems

11. Physical or psychological harm

Addiction: A Brain-centered Condition Whose Visible Symptoms are Behaviors

[1] Mild (2-3), moderate (4-5), severe (≥6)

[2] Not valid if opioid taken as prescribed

APA. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)

Alcohol Use Disorder Treatment

- Mainstay of AUD treatment is medication with behavioral interventions
- FDA-approved medications for AUD:
  - Disulfiram, Naltrexone, Acamprosate
  - Very limited data on both safety and efficacy in pregnancy
- However, naltrexone and acamprosate likely safer than alcohol and untreated AUD in pregnancy and should be considered on individual case basis

Nicotine Use Disorder Treatment

- Addiction to and dependence on cigarettes is physiologic and psychologic, and cessation techniques should include psychosocial interventions and medication
  - Nicotine replacement therapy
  - Bupropion hydrochloride sustained release
  - Varenicline
- Cognitive behavioral therapy and contingency management are associated with a reduction in smoking during pregnancy and decreased risk for infants with low birth weight
- Intervention context and strategies should be individualized

Cannabis Use Disorder Treatment

- No approved medications
- Behavioral therapies: motivational enhancement, cognitive behavioral therapy, contingency management

Stimulant Use Disorder Treatment

- Treatment with hydralazine for hypertensive emergencies
- No FDA approved medication for the treatment of Stimulant Use Disorder
- Treatment rests upon behavioral interventions
- Many medications have been studied with modest effect
  - Topiramate
  - Buprenorphine

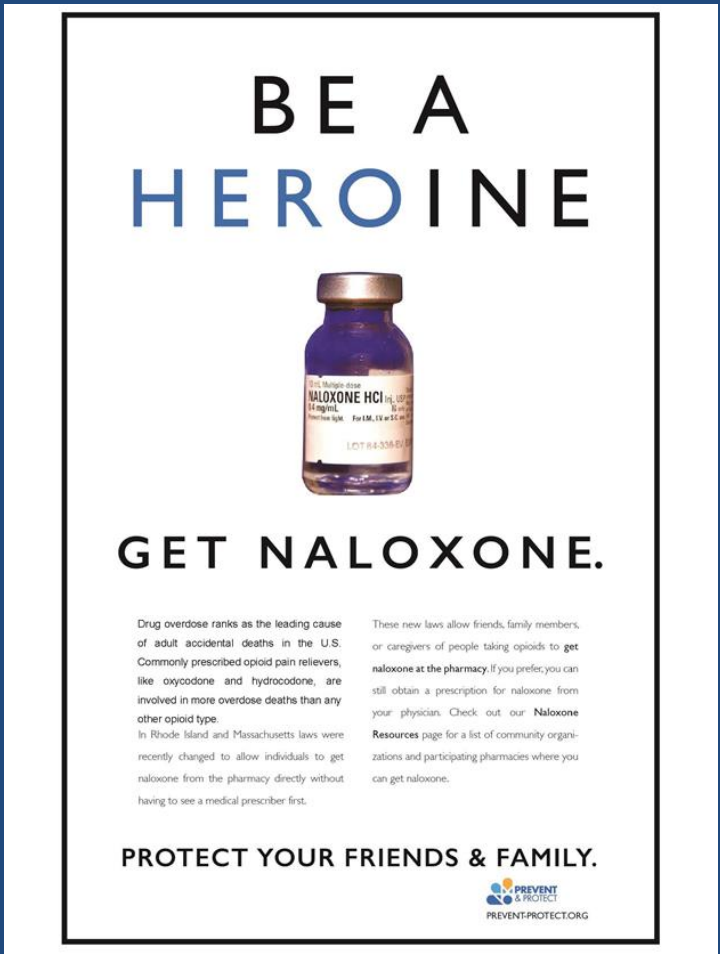
Opioid Use Disorder Treatment

- Methadone and buprenorphine are safest most effective medications to treat OUD in pregnancy
- Buprenorphine combination product (naloxone + bup; “Suboxone”) as safe and effective as mono product (“Subutex”)

Opioid Use Disorder Treatment

- XR-Buprenorphine (“Sublocade”): excipient NMP has caused pre-implantation losses, delayed ossification, reduced fetal weight, developmental delays, and reduced cognitive function at doses equivalent to recommended human doses. Decreased pup survival and malformation and postimplantation losses were reported at 2 and 3 times the human NMP dose.
- XR-Buprenorphine (“Brixadi”) weekly formulation NIDA clinical trail in pregnancy, excipient = alcohol.

Naloxone



- Naloxone is life-saving medication that reverses an overdose
- It is safe to use in pregnancy
- Everyone who uses opioids or who may witness an overdose should be co-prescribed naloxone
- Overdose is a leading cause of maternal death in the US
- Everyone with OUD should receive naloxone upon discharge from the birthing hospitalization

Conceptual Model

Hermeneutical Injustice

Group-based Medical Mistrust

Historic Trauma
Everyday Racism

Structural Inequities

Testimonial Injustice

Experience of Healthcare Discrimination

Clinical Care

Implicit and Explicit Bias

Expectations of Care and Health Outcomes

after Hall JSAT 2021

Resisting Stigma and Discrimination

- Give credibility to people who use drugs, people with addiction, people in recovery
- Treat people as experts
- Engage the community; elevate and support people in recovery
- Center on the most marginal

REIMAGINE SUPPORT

WE ARE EXPERTS ON THE ISSUES & INJUSTICES THAT AFFECT US

RACIALIZED COMMUNITIES • PEOPLE LIVING WITH DISABILITIES • YOUTH • UNDOCUMENTED MIGRANTS • DRUG USERS

WE ASPIRE TO LEAD A PLANNING & ADVOCACY PROCESS THAT INCLUDES & CENTERS DIVERSE VOICES & EXPERIENCES

- FAMILY AUTONOMY
- FINCIAL STABILITY
- ACCESS TO SAFE HOUSING
- MENTAL HEALTH SUPPORT
- RESOURCE BANKS & BABY BOXES.
- COMPREHENSIVE SEX EDUCATION THAT INCLUDES BIRTH & PARENTING EDUCATION.

- FREE OF RACISM & DISCRIMINATION
- FREE OF STIGMATIZATION & CRIMINALIZATION OF BIRTHING PEOPLE WHO ARE USING DRUGS

GROUNDED IN

OUR WORKS REQUIRES RESPONSIVE, FLEXIBLE & ADAPTABLE FUNDING STRUCTURES

- EXPANDED MUTUAL AID
- INDIVIDUAL DONATIONS
- GOVERNMENT SUPPORTS THAT DON'T OVER BURDER ORGANIZATIONS & THE COMMUNITIES THEY SUPPORT.

DIVERSE NEEDS, ISSUES & EFFORTS OVERLAP & INTERSECT

GENDER JUSTICE
REPRODUCTIVE JUSTICE
DRUG LEGALIZATION
PRISON ABOLITION
MEDICAL ANTI-RACISM
PUBLIC HEALTH
HARM REDUCTION
NEO NATAL & PERINATAL CARE
ANTI-DISCRIMINATION
RACIAL JUSTICE

WE FIRST CAME TOGETHER AS A GROUP IN MAY 2019

TO LEARN TOGETHER DISCUSS IDEAS & SHARE SOLUTIONS

WE HAVE CONTINUED OUR WORK THROUGHOUT 2020

OUR VISION HAS EXPANDED

OVERLAPPING CRISES & DISRUPTIONS & THE POWERFUL RESPONSES FROM COMMUNITY-BASED ORGANIZATIONS INSPIRE US & LET US KNOW THAT WE CAN DEMAND MORE.

WE KNOW THAT PROFOUND SYSTEMIC TRANSFORMATIONS ARE POSSIBLE!

THIS WILL BE OUR FOCUS AS WE JOIN FORCES TO LEAD THE WAY

on the Right Mind

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Resisting Stigma By Speaking

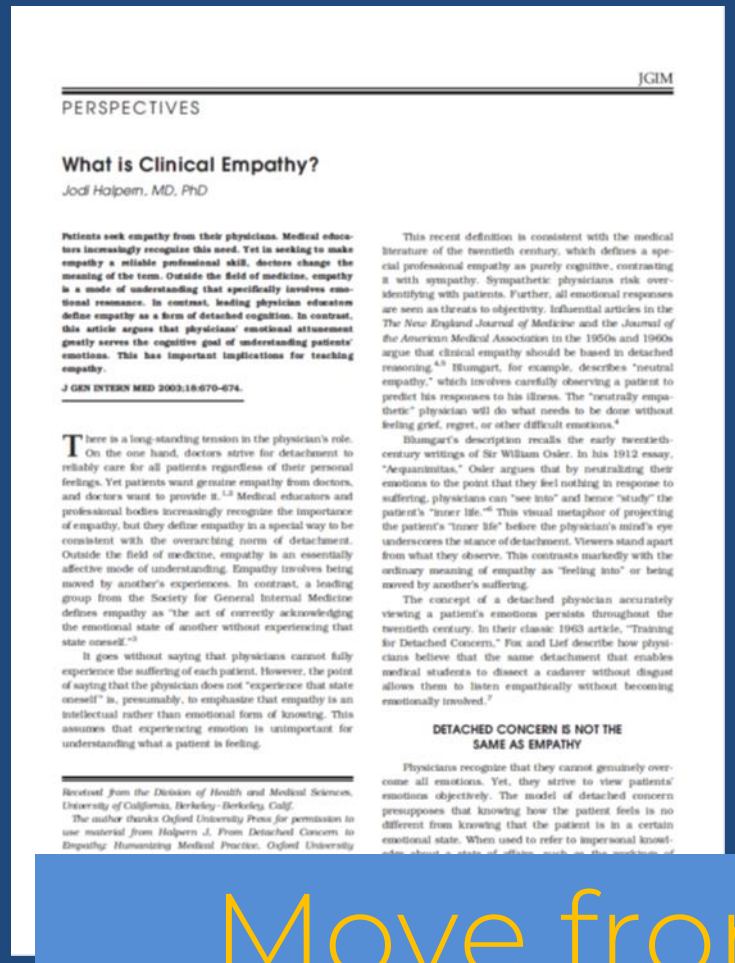
Trust-Building through clinical discussion

- What is the most important thing to you about treatment or recovery?
- What do you know about methadone?
- Do you have any fears or concerns from previous treatment experiences?
- What do you need to feel safe?
- What are you looking for in a provider?
- How do you feel your care is going so far?

Practice Empathy

- Use people’s names
- Smile
- Listen
- Don't interrupt people
- Tune in to non-verbal communication
- Be fully present when you are with people
- Take a personal interest in people

Empathy



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PERSPECTIVES

What is Clinical Empathy?

Jodi Halpern, MD, PhD

Patients seek empathy from their physicians. Medical educators increasingly recognize this need. Yet in seeking to make empathy a reliable professional skill, doctors change the meaning of the term. Outside the field of medicine, empathy is a mode of understanding that specifically involves emotional resonance. In contrast, leading physician educators define empathy as a form of detached cognition. In contrast, this article argues that physicians' emotional attunement greatly serves the cognitive goal of understanding patients' emotions. This has important implications for teaching empathy.

J GEN INTERN MED 2003;18:670–674.

There is a long-standing tension in the physician's role. On the one hand, doctors strive for detachment to reliably care for all patients regardless of their personal feelings. Yet patients want genuine empathy from doctors, and doctors want to provide it.[1,2] Medical educators and professional bodies increasingly recognize the importance of empathy, but they define empathy in a special way to be consistent with the overarching norm of detachment. Outside the field of medicine, empathy is an essentially affective mode of understanding. Empathy involves being moved by another's experiences. In contrast, a leading group from the Society for General Internal Medicine defines empathy as "the act of correctly acknowledging the emotional state of another without experiencing that state oneself."[3]

It goes without saying that physicians cannot fully experience the suffering of each patient. However, the point of saying that the physician does not "experience that state oneself" is, presumably, to emphasize that empathy is an intellectual rather than emotional form of knowing. This assumes that experiencing emotion is unimportant for understanding what a patient is feeling.

This recent definition is consistent with the medical literature of the twentieth century, which defines a special professional empathy as purely cognitive, contrasting it with sympathy. Sympathetic physicians risk overidentifying with patients. Further, all emotional responses are seen as threats to objectivity. Influential articles in the *The New England Journal of Medicine* and the *Journal of the American Medical Association* in the 1950s and 1960s argue that clinical empathy should be based in detached reasoning.[4,5] Blumgart, for example, describes "neutral empathy," which involves carefully observing a patient to predict his responses to his illness. The "neutrally empathetic" physician will do what needs to be done without feeling grief, regret, or other difficult emotions.[4]

Blumgart's description recalls the early twentieth-century writings of Sir William Osler. In his 1912 essay, "Aequanimitas," Osler argues that by neutralizing their emotions to the point that they feel nothing in response to suffering, physicians can "see into" and hence "study" the patient's "inner life."[6] This visual metaphor of projecting the patient's "inner life" before the physician's mind's eye underscores the stance of detachment. Viewers stand apart from what they observe. This contrasts markedly with the ordinary meaning of empathy as "feeling into" or being moved by another's suffering.

The concept of a detached physician accurately viewing a patient's emotions persists throughout the twentieth century. In their classic 1963 article, "Training for Detached Concern," Fox and Lief describe how physicians believe that the same detachment that enables medical students to dissect a cadaver without disgust allows them to listen empathically without becoming emotionally involved.[7]

DETACHED CONCERN IS NOT THE SAME AS EMPATHY

Physicians recognize that they cannot genuinely overcome all emotions. Yet, they strive to view patients' emotions objectively. The model of detached concern presupposes that knowing how the patient feels is no different from knowing that the patient is in a certain emotional state. When used to refer to impersonal knowl-

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- Empathy involves associative reasoning: appreciate the personal meanings of patients' words
- Emotions help guide and hold attention on what is humanly significant: nonverbal attunement
- Empathy facilitates trust and disclosure and can be directly therapeutic: empathy directly enhances therapeutic efficacy
- Empathy makes being a physician more meaningful and satisfying

Move from a Language of Devalue to Language of Empathy

Humility as Trust-Building

Mistrust

Provider

- Mistrust emerges from prejudice
- Acting on mistrust is form of epistemic injustice (both testimonial and hermeneutical)
- Consequences of misplaced trust are minor

Patient

- Mistrust is justified due to history and current discrimination
- Consequences of misplaced trust are severe

Power Differential

Responsibility for overcoming mistrust rests with providers

Mistrust

“When I know you care,
I will care about what you know”

Thank you

Mishka Terplan

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