CO's CURE Podcast
Stigma at the Bedside

Hi, I'm Diane Rossi MacKay, clinical nurse manager for quality improvement with Colorado Hospital Association.

During this CO's CURE podcast, we will address stigma at the bedside, specifically as it relates to pain management and substance use disorder.

I want to begin by reading the position statement from the American Society for Pain Management Nursing on what is encouraged for the nursing profession when caring for patients with substance use disorders.

"Every patient with pain, including those with substance use disorders, has the right to be treated with dignity, respect and high-quality pain assessment and management.

Failure to identify and treat the concurrent conditions of pain and substance use disorders will compromise the ability to treat either condition effectively. Barriers to caring for these patients include stigmatization, misconceptions and limited access to providers skilled in these two categories of disorders."

Our role as caregivers is to advocate for the individual needs of our patients who are in pain, regardless of how we feel about their behaviors

We have an ethical imperative to provide safe and effective pain management to patients with substance use disorders.

Stigma and misconceptions shouldn't be barriers to providing compassionate and effective patient-centered care.

Intuitively we know this, yet how often have we sat in the breakroom and heard the chatter about the "drug seeking "patient in room 301? Or during shift report, our colleague tells us about the patient in 551 who is "manipulative and a pain medication clock watcher."

These kinds of discussions and comments can set the stage for stigmatizing behavior.

What are the conversations taking place in your hospital on your medical and surgical units? More importantly, how are they directly impacting the way you think and ultimately care for your patients?

Those were the tough questions I had to ask myself after attending a pain management conference about four years ago.

At the conference, a speaker shared her personal story about her days as a nurse in the emergency department. As I listened, I could hear the pain in her voice as she relived the moment in time, when she realized that for years, she had not always treated substance use disorder patients in her emergency department with kindness and compassion.

Her “job” she said, was to hydrate, stabilize and release as quickly as possible. These “drug seekers and addicts” were taking up valuable bed space in her busy ER. Stigmatization of this patient population was a daily part of her life until the night she received a call about her 16-year-old son who had overdosed in a nearby park.

Rushing to the emergency department, she found the ER nurse hydrating, stabilizing, and pushing to release. I will never forget the next thing she said: “I told them he wasn’t ready to go. The nurse looked at my son, then looked at me and said he’s ready. With that, she tossed the discharge papers on his chest, turned and walked out.” No kindness, no compassion – just judgment.

How many patients in our care have we unintentionally judged?

In a 2011 article, "*Is my patient drug-seeking or in pain?*" Paul Arnstein suggests stigma is rooted in shame and guilt and interferes with the development of trust and the establishment of a therapeutic relationship. According to that paper, when our patients feel judged because of something we have said, they are more likely to deny a substance use disorder or addiction. (Arnstein, 2011).

Margo McCaffery, an independent nurse consultant in the care of patients with pain, says that the use of stigmatizing terms, such as drug-seeking, creates prejudice and promotes a shame-based context of care (McCaffery et al., 2005). Other stigmatizing words like junkie or addict are terms many healthcare professionals use without a second thought. While we may not use these terms in front of a patient or family member, what we say outside the room, at the nurse’s station or lounge can come across in how we care for patient at the bedside.

Professor Albert Mehrabian, the author of *Silent Messages*, has pioneered the understanding of communications since the 1960s. His communication theory of verbal, non-verbal, body language reveals a 7-38-55 split in how we effectively communicate messages. According to Dr. Mehrabian, only 7% of effective communication is in the words we say. 38% is **how** we say those words or our tone-of-voice and 55% of effective communication is in our body language. So my words might tell you one thing, but my body language and tone of voice are sending a different message.

Eye contact, the use of touch, and sitting at the bedside to alleviate fear and anxiety are good ways to communicate that "I care about you.”

As a nurse, it’s difficult to admit I have engaged in stigmatizing behaviors over the years. The same coffee cup conversations that have unintentionally set up barriers to caring for patients

with substance use disorders. I discovered I had many misconceptions and lacked education about the disease of addiction.

There are several common misconceptions regarding pain and substance use disorders or addiction. These misconceptions can occur among clinicians as well as patients, families and the public, which in turn feed into the negative interactions, assessments, treatment and outcomes.

The first and most impactful misconception is the notion that addiction is a choice, rather than a disease. Just like diabetes is a disease of the kidneys, and CHF is a disease of the heart, addiction is a disease of the brain.

The damage to the brain is rapid and reduces a patient's control over impulses. This disease model of addiction is an evidence-based medical model and focuses on the treating of the disease, helping to alleviate the stigma.

Margo McCaffery, in her article, *Stigma, and Misconceptions Related to Addictive Disease*, found changing many long-held beliefs about substance use disorder requires repeated education about the disease model of addiction.

McCaffery continues in her article with this quote: *when asked, most nurses say they do not want punitive attitudes to interfere with the quality of their care. They believe that they could benefit from discussions about patients addicted to opioids. To prevent these negative feelings from affecting care, nurses often feel that it helps to begin by admitting that they do not like a specific patient. These types of conversations open the door to explaining that such a patient has a brain disease.*

McCaffery begins education by sharing several misconceptions to challenge nurses thinking about substance use disorder and what we believe to be addictive behaviors. Behaviors that have become engrained in many nurses considering leading to barriers to patient-centered care. These are some of the most common misconceptions that resonated with me:

Misconception #1:

The patient obtains opioids from more than one prescriber or more than one emergency department; we have already labeled this patient a "frequent flyer."

Possible explanation:

McCaffery asks us to challenge our thinking by asking ourselves: *Is there an explanation we have not considered?* Perhaps this patient might not manage their pain medications

appropriately. Maybe no single prescriber or emergency department has developed an effective pain management plan.

Misconception #2:

The patient tells inconsistent stories about pain or medical history.

Possible explanation:

Perhaps there is inconsistent recall that can be caused by many factors such as a psychiatric condition, cognitive impairment or adverse effects from other medications.

Present pain intensity also affects a patient's recall of chronic pain. When the "current" pain is at a low intensity, the patient doesn't remember pain having severe pain because our brain doesn't remember the pain at all. Therefore, the patient doesn't remember using a lot of pain medication. We should not be surprised when patients tell inconsistent stories about their pain.

Misconception #3:

The patient requests a specific opioid by name and sometimes by route of administration and interval between doses. How often have we heard a patient ask for “Dilaudid”?

Possible explanation:

This patient is likely well-educated and has probably had pain, often chronic pain. They already know what works best. If a patient has asthma and tells you about medications and doses that help, this is welcome information. We should also welcome information about analgesics because it helps formulate the pain treatment plan.

Misconception #4:

Patient "enjoys" his opioid.

Possible explanation: Once pain is relieved, the patient naturally returns to a healthy or happier mood and engages in more activities such as talking, ambulating and even going out for a cigarette.

The above examples represent some of the common misconceptions surrounding substance use disorder patients. Having the knowledge and resources to appropriately treat and manage pain in patients with coexisting substance use disorders is paramount. (McCaffery, 2011)

One of the newest resources available to all clinicians is the CO's CURE Hospital Medicine Pilot 2019 ALTO pathways. These pathways offer clinicians guidelines on how to engage patients in unique ways to manage pain using opioids as a last resort. Reducing the opportunity for opioid exposure will go a long way in fighting the opioid epidemic.

As the American Society for Pain Management Nursing Position Statement reminds us:
"Every patient with pain, including those with substance use disorders, has the right to be treated with dignity, respect, and high-quality pain assessment and management.

Barriers to caring for these patients include stigmatization, misconceptions, and limited access to providers skilled in these disorders."

What role do each of us play in removing these barriers? How can you make a difference at the bedside for the next patient you care for who suffers from a substance use disorder?

Thank you for taking the time to join us for this CO's CURE podcast on addressing stigma at the bedside.

Reference:

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