April 2022

Applied Anthropology of Addiction in Clinical Spaces: co-Developing and Assessing a Novel Opioid Treatment Pathway

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Applied Anthropology of Addiction in Clinical Spaces: co-Developing and Assessing a Novel Opioid Treatment Pathway

by

Heather Diane Henderson

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a concentration in Medical Anthropology Department of Anthropology College of Arts and Sciences University of South Florida

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Date of Approval:
March 31st, 2022

Keywords: Emergency Medicine, Healthcare Trajectories, Ethnographically Informed Care, Structural Determinants of Health, Clinically Applied Medical Anthropology

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Dedication

I would like to dedicate this dissertation to:

- Everyone in each phase of my life that could not access care for addiction, mental health crises, and other fundamental social supports to stay safe and healthy. For every time your pain and anxieties were dismissed as being all in your head or just your nerves, or every time you found yourself in jail rather than treatment. For all the confusion, pain, and chaos that structural vulnerability can bring. To everyone who didn’t make it out and are still stuck in the viscous cycle of poverty and addiction.

- To all the patients that entrusted me with their story and counted on me to do something beyond just listen. Every kindred spirit who found temporary solace in our conversations, knowing that I saw them, understood them, and would help them.

- To everyone who seeks out treatment in any form because they are in crisis due to addiction and are looked down on as other or less than due to structural inequality.

I vow to use this degree as another tool in the fight to change our current healthcare system to one that provides equal access to addiction care, with dignified and empowering treatment options and desperately needed structural supports that meet you where you are at, without judgement or expectation.

In Loving Memory:
Frankie Diane Henderson
Gary Ray Dula
Randall Wayne Phelps
Acknowledgements

As a first-generation college student, it would be impossible to acknowledge everyone who helped me to get here and played a role in this study coming to fruition. I am eternally grateful for all the professors along my academic journey who saw something more in me and kept pushing and supporting me, even through periods of turbulence. To all the physicians and other addiction treatment providers who took the time to open up to me about their struggles in providing care for opioid use disorder, and for working together with me to change our corner of the healthcare system.

I am exceedingly fortunate to have had access to the spaces which made this research possible. I would like to say a massive thank you to the hospital that has allowed me to work in the emergency department space for the last five years and has taken a chance on all my crazy ideas. For the addiction treatment centers who opened their doors and their hearts, banding together with us to change the way addiction care is understood and delivered. For the political spaces and processes I was privileged to be a part of, which allowed for desperately needed policy and legislative change.

To everyone I have met along this journey who let their guard down, regardless of their professional positions or affiliations, and shared their stories of recovery with me, and strove to help this project in any way they could. You will always inspire me. To the managing entity who provided critical funding so this project could be possible. Most importantly to my husband and daughter, who have supported me and stuck it out during all the highs and lows of this research process.
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Abstract

Historically, there has been no clear treatment pathway for opioid use disorder (OUD) patients who seek emergency care. Utilizing a trajectories of addiction framework, this dissertation presents insights from an applied anthropology of addiction study in an acute care setting to build a medication for opioid use disorder (MOUD) treatment pathway, aiming to break down the stigma related to opioid use disorder (OUD) and mitigate a lack of treatment options. This dissertation took place in an urban trauma center in Florida, from 2018 to 2021. With almost 1500 hours of participant observation, hundreds of informal interviews, and 30 formal interviews, I consider both the qualitative and quantitative outcomes of the BRIDGE (Building Recovery Integration for Drug users into Emergency medicine) pathway, created in conjunction with emergency medicine physicians.

The research findings include: (1) Drawing on ethnographic interviews, observations, and field notes, the study examines how the BRIDGE was developed based on ethnographic analysis of OUD patient/physician experiences and how it has transformed emergency care for OUD for patients, physicians, and community treatment providers; (2) Quantitative outcomes for assessing the success of patient care suggest implementation of this hybrid pathway has the potential for success; (3) Previous lack of engagement with opioid use patients by physicians can be better understood by examining the concept of learned helplessness within the context of clinical care and education; (4) Strategies such as integrating ethnographically-informed care and person-first care strategies into acute encounters with interventions such as the BRIDGE are necessary; (5) Uncovers the possibility of a learned helplessness in relation to those
perceived to be in positions of power; (6) Critically examines the concept of a ‘fixed trajectory’ in addiction, where addiction is seen as fixed state of permanency and largely untreatable; (7) Explores the benefits of creating applied clinical interventions with physicians as stakeholders.

This work further investigates, extends, and applies findings from, “I am More Than my Addiction: Perceptions of Stigma and Access to Care in Acute Opioid Crisis”, which was an Emergency Department-based ethnography of the acute care experiences of multiple actors related to providing and seeking care for opioid-related emergencies, as well creating the space for considering how anthropology can be clinically applied in acute spaces, while still taking a critical view of the biomedical system. This dissertation adds to medical anthropology theory through the consideration of how ethnography can be infused into the clinical space, and function as an actionable next step in creating targeted interventions to improve patient experiences and treatment. Moreover, how these interventions can be utilized to empower physicians in providing care, which may bolster against the effects of helplessness and burnout that often lead to poor patient outcomes. Finally, this study adds to an anthropology of addiction with the addition of a ‘fixed trajectory’ regarding drug use, where the user is seen as a fixed, static, and homogenous archetype considered untreatable in biomedicine and unfixable in society.
Chapter One
Introduction

This dissertation is an example of an applied anthropology intervention based on eliciting lived experiences of patients and providers (Kleinman 1986; 2006; Kaplan-Myrth 2007), using interviews, clinical observation, and participant observation to build, and then evaluate, an alternative treatment pathway for patients presenting to the emergency department (ED) with opioid use disorder (OUD). This research builds upon my work in the same hospital and community as my M.A. thesis, by integrating insights from that critical medical anthropology study, focused on understanding addiction treatment in an acute care setting (Henderson 2018). The main finding of my previous research was how pervasive stigma towards patients with addiction works to circumvent successful treatment for OUD. The dissertation research aims to document the social interactions and relations that contribute to OUD-related stigma in an ED setting and beyond, as well as to co-create, with physicians and other health-care professionals in that space, a medication for opioid use disorder (MOUD) treatment pathway to address a lack of acute care treatment options for OUD. Hospital-based ethnography is a powerful tool for understanding the lived experiences of physicians and patients, as well as how that combines with knowledge and perceptions around addiction in ways that can create barriers to care. Recent hospital ethnographies have largely focused on elucidating the lived experiences of patients to illustrate systems critiques (Garcia 2010; Sue 2019; Reyes-Foster
2019). To date, however, I argue that hospital ethnography and other medical anthropology work in these settings have fallen short of blending anthropological theory and praxis to craft successful clinical interventions. This study aims to achieve this blended intervention to 1) reframe how physicians treat and interact with OUD patients by addressing the specific structural forces that comprise this disease for patients, and 2) demonstrate how the co-creation of a clinical intervention with physicians, patients, and anthropologists providing input may work to address the lack of education, training, systemic and structural supports available to physicians (Wood et al. 2013; Hoffman 2018; Arya et al. 2019; Scutti 2019; Morreale et al. 2020; Wedge 2020; Lai 2020; Kilmas 2021) in the acute OUD treatment and follow-up that physicians can offer.

By uncovering what experiences OUD patients have with caregivers and staff while under emergency care, what stigmas patients generally experience related to their care either during or directly after crisis, and what challenges healthcare providers describe while facilitating this care—addiction can be leveraged as a medical condition in the acute space which provides the possibility to create a targeted clinical treatment pathway. One key advantage of this approach that is promising is the ability to critically assess current treatment structures, the history of addiction treatment in an emergency setting, and how these factors blend in a way that could affect patient/provider interactions. Further, because stigma is so pervasive around addiction in general, especially for OUD within the context of the current opioid epidemic, the treatment structures in place for other disease states (such as strokes, sepsis, and diabetes) do not exist for this one, and still need to be built. Moreover, the moment of crisis a patient experiences during an acute opioid emergency is a crucial intervention point,
as it represents a critical time-period when an individual could be most open to the idea of entering some form of treatment.

**America's Opioid Crisis**

The United States is in the midst of an opioid crisis. An estimated 2.1 million Americans had an active opioid use disorder as of 2016; in 2019 rates of opioid overdose deaths increased by 500% (Parker et al. 2019). In 2015, economists Anne Case and Angus Deaton documented a marked rise in the morbidity and mortality rates of middle-aged white non-Hispanics in the United States after 1998 in what they dubbed *deaths of despair* (Case and Deaton 2015). This term was used to describe an unprecedented rate of deaths connected to suicides, drug overdoses, and alcohol-related liver diseases. This focus on the rise in deaths associated with the ongoing opioid epidemic in the United States uncovered a crisis of joblessness, increased poverty, hopelessness, and a breakdown in traditional support mechanisms rooted in family, community, or religion (Woolf and Braveman 2013). Finding a way out of this crisis will require a recognition of these social and structural issues that comprise this epidemic. This study aims to answer a call for more integrative, interdisciplinary, and innovative approaches to treatment and recovery. This is discussed in more detail in the section that explains the rationale for the study, but first, I turn to an exploration of history of the phenomena known as addiction in the U.S. and how anthropologists have approached its study.

Considering the long history of addiction in the U.S. and understanding the ways anthropologists approach the study of addiction and interventions in clinical spaces is critically important to developing solutions to America’s opioid crisis. This importance was crystalized for
me on the very first day of my observation at the hospital, back in May of 2017. I had never
worked in a hospital before, and was still trying to find my bearings on what to do, how to be
useful, where to observe, etc. In my hospital field site, the ED is organized in clusters of rooms,
with physician stations and nursing stations, referred to as ‘pods.’ I took a seat in pod 5 at a
computer, which happened to be right next to a patient’s room. As I began to organize what I
wanted to do during my shift that day, I heard the patient in the room next to me calling out
over and over for help. I looked around and did not see any staff in the hallway, so I poked my
head in the patient’s room to ask what they needed. I was greeted by the roving, dark brown
eyes of a gaunt young man, whose hands, neck, and arms were entirely covered in slowly
pooling streams of bright red blood. “Can I get a washcloth to wipe myself off?” He asked
pleadingly. Shocked, I let him know that I would find his nurse for him.

It turns out that this young man was in the ED that day for a mental health crisis
secondary to bipolar disorder, and the severe anxiety related to his manic episode had caused
him to pick and scratch wounds into his face and neck. He also happened to have a history of
opioid and methamphetamine use in his chart but was not under the influence of anything
during this visit. After asking around, I found out that his nurse was in the nutritional breezeway
behind the nursing station. “Hi, are you L, room 510’s nurse”? I asked politely. They rolled their
eyes; “Yeah, why. What does he want now?” I relayed the patient’s message about needing a
washcloth, and let them know what state the patient was in. “Oh my God. If I have to take care
of another one of these fucking junkie’s, I will blow my Goddamn head off” was the response I
got; this was my first day in the ED, as an observer. I was there to observe stigma in seeking
care related to addiction. After seeing this, I wanted to know: what potentially caused such an
outsized reaction towards this patient? Turning to a history of addiction helped me better understand what was behind this disturbing encounter and set me on a pathway toward my dissertation research.

**What is Addiction?**

The present-day description of addiction began to rapidly coalesce in “Anglo-American countries with the formation of the disease concept of alcoholism during the early industrial age” (Raikhel and Garriott 2013: 11). Distress around industrialization, coupled with the introduction of cheaply acquired distilled liquors like gin and whiskey rapidly escalated workforce issues as factories needed a dependable workforce (Vallely 2005). This early epidemic resulted in the temperance movement to first moderate the consumption of alcohol, and later call for total abstinence from drinking all together. This early nineteenth century movement had heavy religious and puritanical undertones, whereas citizens were seen as unvirtuous and immoral, and many Americans “feared that... these ungodly and unscrupulous people posed a threat to America's political system” (Ohio History, 2020). Many of these same social holdovers still exist today, even if subconsciously, in how addiction is viewed in society. Before unpacking how addiction is viewed in society, and how that complicates emergency care, it is important to consider how difficult it could be to understand the concept of addiction outside of broad social opinions due to the incongruence of numerous addiction definitions.

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association (APA), which provides revised criteria to be used by clinicians as they evaluate and diagnose different mental health conditions, addiction is listed as “a
complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence (American Psychiatric Association, 2013).” Here someone with addiction will focus intensely on one or more substances, with the substance(s) eventually taking over the user’s life. They “keep using alcohol or a drug even when they know it will cause problems (American Psychiatric Association, 2013). According to the National Institute on Drug Abuse, addiction is both a “complex brain disorder and a mental illness” and is the most severe form of many versions of substance use disorder (NIDA, 2007: 5).

According to the American Society for Addiction Medicine, addiction is defined as a “primary, chronic disease of brain reward, motivation, and related circuitry disfunction (ASAM, 2019).” The “Big Book” of Alcoholics Anonymous calls it the “old, insidious, insanity, that first drink—a threefold illness: a physical allergy, a mental obsession, and a spiritual malady (Wilson, 1976). In the next sections, I will attempt to construct a narrative of biomedical understandings of addiction and the social construction of addiction, and how a binary, either/or mentality with seeing addiction as fixed (“either you are an addict, or you are not) interacts in ways that obfuscates providing appropriate care for those experiencing addiction and seeking care in hospital settings.

Addiction as it Exists in a Biomedical Worldview

In the 1990’s, then President George Bush dedicated a large number of resources to neuroscience research as a contingency of the war on drugs “as studies provide greater insight into how people become addicted to drugs and how drugs affect the brain” (Campbell, 2007). The brain became the “target organ of addiction” (DuPont 1997: 93; Campbell 2007), and drug
addiction was repackaged as a chronic relapsing brain disorder. This new localization of
addiction to the brain “dislocated it from the rest of the physical... and social body” (Campbell
2007: 200). Institutions such as NIDA and ASAM assert that addiction is predominantly
biological, signifying a pathological state of brain dysfunction, as “brain structures involved in
rewarding human behavior cannot distinguish between the chemistry of naturally occurring
neurotransmitters on the one hand, and of artificial drugs on the other” Vrecko 2010: 53). A
principal model of this reward system malfunction is known as the dopamine hypothesis.

The Dopamine Hypothesis of Addiction defines a process whereby drugs “hijack” the
brains reward systems by:

“producing an overriding reward effects by neuropharmacological actions on a common
brain reward circuit called the extended amygdala. The extended amygdala involves the
essential dopaminergic system and specific subregions of the basal forebrain, such as the
shell of the nucleus accumbens, the bed nucleus of the stria terminalis, and the central
nucleus of the amygdala “(Leshner and Koob: 99).

Various drugs then stimulate distinct parts of the brains rewards system circuitry, though all
dysregulation of brain reward circuitry affects the mesolimbic dopamine system, known as the
dopamine hypothesis. Positron emission tomography (PET) imaging studies (Martinez et al.
2011; Martinez et al. 2007; Volkow et al. 2009; Breier et al. 1997) show that striatal dopamine
transmission is impaired in drug and alcohol addiction. PET imaging reveals that “dopamine D_{2/3}
receptor availability is reduced in cocaine, alcohol, tobacco, opiate, and methamphetamine
dependent subjects compared to healthy control subjects” (Martinez et al. 2007: 192). Further,
both chronic opiate use and withdrawal have been shown to decrease striatal dopamine
transmissions, and in animals this decrease in dopamine extended periods of acute withdrawal,
suggesting that a “hypodopaminergic state contributes to the motivation to maintain drug use
and relapse (Martinez et al. 2007: 195; Melis and Spiga 2005; Di Chiara and Bassareo 2007). This
is seen in patients with OUD as well, as the brain slowly loses the ability to make its own
dopamine and becomes ever more reliant on the manufactured dopamine rush of opioids.
Bouts of depression debilitating withdrawal symptoms when not using points to the same
motivation to maintain the cycle of drug use and relapse.

Repeated and prolonged drug use leads to physical dependence, and the mechanism for
this transition involves, at the behavioral level, a progressive dysregulation of brain reward
circuitry and a recruitment of brain stress systems such as the corticotropin-releasing factor.
The molecular mechanisms of signal transduction in these systems are a likely target for
residual changes in that they convey allostatic changes in reward set point, which lead to
vulnerability to relapse. Dopamine hypothesis aside, addiction as a disease does not appear to
meet the criteria of biomedicine (Raikhel and Garriott 2013). Therapy to treat pathology is a
significant success marker in biomedicine, and though there have been pharmacological
treatments introduced to address addiction, the majority of available therapies (twelve step
programs, detoxification, cognitive behavioral therapy, motivational interviewing, drug court,
etc.) are a hodgepodge collection of socio-behavioral markers and subjective symptom
reporting.

May (2001) speaks to the difficulty of medicalizing addiction, and the struggles of
clinicians to convert addiction from a moral to medical model (389). Due to the complication of
converting voiced symptoms into pathological signs, May suggests that we can speak only of a “quasi-disease model of addiction” in biomedicine, due to an absence of clear organic disease markers, which leaves physicians to heavily rely on patients’ self-reports for diagnosis, “rendering diagnosis largely an issue of self-identification” (Raikhel and Garriot 2013: 14). The pathologizing of addiction is complex and appears to discard inherent socio-behavioral components intertwined and irremovable from this disease. However, addiction treatment utilizing this model “may perform normalizing operations through the creation of pathological identities” (Vrecko 2010: 64). Normalizing addiction is crucial in shifting away from moral responsibility to combat stigma and negative social perceptions that often prevent recovery and result in further complications with addiction up to and including loss of life (Dyer et al. 2008; Lefebvre et al. 2020; Adams and Volkow 2020; Atkins et al. 2022).

Addiction as it Exists in the Social Collective

“And above all, we must reduce drug use for one great moral reason: Over time, drugs rob men, women, and children of their dignity, and of their character. Illegal drugs are the enemies of ambition and hope. And when we fight against drugs, we fight for the souls of our fellow Americans”. (The White House, 2001)

The exodus of addiction from a personal failing to a brain disorder was born from researchers’ estimation that in order for pharmacological treatment to successfully “produce socially appropriate behavior (Vrecko 2010), the condition should be distanced from older, cultural lexicons of moral turpitude, stigma, and weak will” (Campbell 2013). Biological and
social science studies now tend to categorize addictive behaviors in two different ways: as the symptoms of a disease and as a failure of self-control (Foddy and Savulkescu 2010: 1). In this section I will deal with the latter, as the concepts of choice and personal responsibility are dominant social narratives in the discourse of addiction both in and out of emergency care, and often stand in opposition to the biomedical disease model.

According to Heyman (2009), people who use drugs “repeatedly make choices that are not in their long-term interest, and this suboptimal thinking results in a ‘disorder of choice.’” In the book Addiction is a Choice, the chapter aptly titled, “Busting the Disease-Model Cult,” Schaler claims that the “most upsetting challenge to the disease model cultist is the claim that addiction is a choice (Schaler 2011: 87). Making the salient choice of repetitive drug use is then seen as a negative behavior, “better explained by psychological and environmental factors than by physiology and the chemical properties of drugs (Schaler 2011: 89). Volkow (2004) problematizes the concept of choice, stating “the dilemma of the modern understanding of addiction is that choice leads to a lack of choice, increasingly leading to the search for new compounds to repair the machinery of choice (Saris 2013: 274).”

I argue that the invented binary of ‘choosing to use drugs’ or ‘not choosing to use drugs’ is not only unproductive, but often slows progress in understanding the nuances of individual addicted experiences and addiction treatment, while also muddying the waters of public perception. These factors then function as a means to reify historical themes of the immoral or weak-willed addict (Nick and Segal 2016). Saris (2103) also grapples with the binary constructs of the neurobiological (brain disease) model of addiction and the notion of the free-willing subject (choice) and argues for the need to have a ‘more robust and better theorized’
commitment to the construction of addiction that incorporates both of these notions in a more complex way; grounding the neurobiology of addiction into the collective and individual lived realities of this social disease (Saris 2013: 281). Further, Saris and colleagues (Singer 2001; Lende 2005, 2012; Campbell 2010; Vrecko 2010) argue that a bio-cultural focus on addiction functions as an entry point for the ‘critical engagement with the biological sciences’ where the integration of anthropological analysis to effect change on the notions of choice and addiction are ‘very promising’ (Saris 2013: 280). The following section, which explores the ways alcohol, and wine in particular, is viewed as socially acceptable, and possibly even necessary for surviving motherhood, is an example of how social narratives determine who is deemed an addict, versus what is normalized and socially acceptable with regards to licit and illicit substances.

“**This Mama Needs Some Wine**: Double Standards in Drug Use

It seems like I can’t make it two feet in most stores now without seeing something related to motherhood and the absolute necessity for wine, which has become particularly egregious after the onset of COVID-19. Shelves, racks, and rows littered with merchandise: ‘Mommy Juice’, ‘Momma Shark needs a drink, DO-DO-DO-DO’, ‘Raising Tiny Humans One Glass at a Time’, ‘Mommy’s Sippy Cup’, Liquid Patience’, Be Kind, Please Re-Wine’... the list is endless. Not to say that there is anything wrong with moms taking a much needed break and enjoying a glass of wine. What is incongruous, is the socially constructed narrative that results in one controlled substance being considered cute, fun, and necessary for good parenting (wine), while another substance is reviled, deviant, and deadly (opioids). I don’t know about you, but I
have never seen a shirt that says, ‘This Mama Needs a Shot of Heroin.’ With the above comparison, you actually get a two-for-one; the stigma associated with mothers using illicit drugs can be nearly inconceivable in its strength and immediacy. But where and how are such notions of what is legal and permissible, as opposed to something malignant, to be eradicated at all costs, shared, and circulated?

Alcohol was actually deemed the most harmful out of multiple other substances in a recent analysis (Nutt et al. 2010), and yet the social narrative (and a near-constant marketing deluge) persists that to be sexy, fun, “blow off steam,” “loosen up at parties,” enjoy the holidays, or be a good gift-giver on Mother’s Day, we must turn to alcohol. Less widely known, however, is that many drugs that currently carry criminal penalties began life as useful medicinal therapies, such as opiates, cocaine, MDMA, and amphetamines—they were often available over the counter at pharmacies or through licensed sellers. For example, take the below marketing ad for ‘cocaine-infused toothache drops.’

![Figure 1.1: Advertisement for Cocaine-Infused Toothache Drops, 1885](image)

This was perfectly acceptable in 1885, but in 2022 not so much. This double standard can often mean the difference between someone being considered ‘just down on their luck’ and
someone undeserving of care. Some also vehemently espouse that alcohol is a gateway drug to other, more nefarious, life ruining substances like cocaine, heroin, or methamphetamines (Kandel 2002; Grau et al. 2007; Degenhardt et al. 2009; Kirby and Barry 2012; Hill 2015). The below image, provided by actor and comedian Russel Brand (in recovery from OUD) problematizes this gateway notion, offering in a manageable soundbite much needed structural context to substance use; structural context that is often left out of a short ED encounter. The following sections will analyze this concept of structural context when navigating disease and illness in the clinical space, which sees addiction as a symptom of much larger forces, such as trauma, abuse, and other adverse events during childhood development.

![Image]

*Figure 1.2: Excerpt from "Recovery: Freedom from our Addictions" (Brand 2017).*

**Navigating Disease and Illness in the Clinical Space**

Along with understanding the biomedical concept of addiction as brain disease, it is also essential to understand how individuals make sense of and experience addiction as a largely untreatable illness or social dysfunction. The disease versus illness model is not a new concept;
in medicine, the distinction was made in Cassell’s seminal work (1978) on subjectively and suffering, stating “Disease is something an organ has, illness is something a man has.” In social science, a large body of scholarship exists around the differences between disease and illness, and how this affects patient and provider interaction (Fabrega, 1973, 1975; Eisenberg, 1977; Cassell, 1978; Kleinman, 1980; 1981). In essence, disease is something to be *cured*; illness is something that needs to be *managed*. Cassell (2004: 32) describes this suffering as “the state of severe distress associated with events that threaten the intactness of a person.”

In this description, a *person* is “an intricate composite of past experiences, future hopes, roles, duties, relationships, and sociocultural and political norms” (Tate and Pearlman 2019: 97). Biomedicine commonly absorbs this reductionist dichotomy, relegating suffering to a clinically insignificant subjective experience, where disease then becomes the objective orientation by which to cure the “abnormalities of the structure and function of body organs and systems” (Eisenberg, 1977: 11). Medical anthropology’s focus on the importance of experiential outcomes allows for the construction of suffering as a social experience which may have value during the clinical encounter (Manderson, Cartwright and Hardon 2012: 2). Another key consideration often missing from ED encounters, and the social narrative on addiction at large, is the reality of how structure affects a person’s risk for developing a substance use disorder.

**Addiction and Structure**

Figure 1.3 illustrates the structural complexity involved in the development of a substance use disorder or other mental and/or physical health conditions, which can be
understood by examining Adverse Childhood Events (ACE’s). An ACE score is a tally of different types of abuse, neglect, and other hallmarks of a rough childhood. According to the Adverse Childhood Experiences study, the rougher your childhood, the higher your score is likely to be and the higher your risk for later health problems (Starecheski 2015). ACEs are divided into three types: Abuse, Neglect, and Household Dysfunction. Within those three types, there is physical abuse, emotional abuse, and sexual abuse; physical and emotional neglect; and mental illness, incarcerated relatives, maternal violence, substance use, and divorce, respectively.

![Figure 1.3: Lifetime Effects from ACEs (FSU, 2021)](image_url)

Better understanding of the role(s) of ACEs for OUD patients presenting in the ED is critical to this study because nearly every patient I spoke to, in both formal and informal interviews, grounded their story of addiction in childhood to frame why they may have developed OUD—each recounting a painful history comprised of multiple ACEs. This is further explored in chapter
Anthropology of Addiction

Anthropologists Raikhel and Garriott (2013) stress that addiction is particularly relevant as an object of anthropological inquiry because it “sits at the crossroads of some of the issues that most define the world today—the role of scientific [particularly bioscientific] knowledge in the shaping of identity, selfhood, and subjectivity; the mutual transformation of novel medical technologies and the cultural settings in which they are enacted; and the mediation of biological and psychological systems and social and political-economic ones by subjective and embodied meaning and experience” (1).

During the civil upheaval of the 1960’s, including the Vietnam War, hippie counterculture and psychedelic drug use, and intense political activism around numerous issues (including racial discrimination and gender roles) instigated the field of anthropology to shift toward conducting research in western societies, with the hope of applying anthropology to pressing social issues (Rylko-Bauer et al. 2006; Wesson 2011). Anthropological research on drug use in particular leveraged participant observation and ethnography to frame addiction as a ‘subculture’ (Friedman and Des Jarlais 1986), and by doing so illuminated drug use as something other than choice or pathology. This identification of drug use as a culture unto itself with meaning, norms,
and collective social identities has made significant contributions to addiction science (Singer 2012).

Further, ethnographic study shows that “the lived worlds and self-identities of drug users have cultural order and socially constructed purpose and meaning” (Singer 2012: 1748). By employing ethnographic methodology to become one with populations studied, anthropology is able to reveal diverse cultural significance surrounding drug use and addiction at the collective and individual level, give voice to the individuality of drug users, uncover the cultural and social fabric of communal and solitary drug use and subsequent structural considerations, and reveal ‘hidden populations’ of drug users not associated to social or health services (Carlson et al. 1994; Singer 2011; 2012).

Rationale and Significance

Impetus for this study

Patients in crisis due to opioid use (either via overdose or withdrawal) have typically had to rely on the emergency department as a safety net for care during their crisis. Unfortunately, there has been no clear way forward for physicians to treat patients acutely, so they were historically discharged with little resolution (Hawk and D’Onofrio 2018; D’Onofrio et al. 2015). This study grew out of my master’s thesis research, titled “I am More Than my Addiction: Perceptions of Stigma and Access to Care in Acute Opioid Crisis”, which was an ED-based ethnography of the acute care experiences of multiple actors related to providing and seeking care for opioid emergencies at an urban trauma center in Florida (Henderson 2018). The findings of this ethnography revealed a vital next step in the successful treatment of OUD,
realized through the integration of anthropology in a biomedical setting to inform new models of acute and downstream\(^1\) care, where key actors (physicians and patients) shaped the process and the outcome of an applied intervention so that it was most useful and impactful in that space.

*Anthropology and Clinical Spaces*

There exists a robust body of literature on anthropology and clinical spaces. Hunter et al. (2008) examines the phenomenon of pediatric unit critical events (e.g., a baby born jaundiced, or a toddler with a brain injury) as not only a causal biomedical instance, but also a socio-cultural event, citing the importance of the flow of both official information (medical charts, histories) and informal information (meetings in hallways, patient discussions in break rooms) in the quality of patient care and potential for medical error. Horsley (2008) explores death spaces and the scientific gaze by approaching embodiment in a unique way with an ethnography of co-constructed daily interactions between the living and the materially dead through fieldwork in a hospital mortuary. Death, Horsley says, has been ‘hospitalized’ ‘colonialized; and sanitized’ but the dead still “remain social beings” (Horsely 2008: 134). A rich body of anthropological literature exists on cancer patients, both in and out of the ward, ranging from the cancer diagnosis itself, how cancer is embodied, how cancer patients and survivors make sense of their condition, the racialization of cancer treatment, community based cancer advocacy, cancer patients and their relationship to pain management, social

\(^1\) Downstream interventions and strategies focus on providing equitable access to care and services after the ED encounter to mitigate the negative impacts of disadvantage on health (NCCDH 2021).
stigma and cancer, and depression rates and access to mental health care among minority populations, among others (Mulemi 2008; Mathews 2004; 2015; Lende and Lachiondo 2009; Burke and Mathews 2017; Dyer 2008; Martinez Tyson 2015; 2008; Carrion et al. 2013).

Anthropological research on addiction is not confined to clinical spaces alone. For example, there are several dynamic ethnographies that track drug users through clinical care and community living. Chenhall (2008) examined how the informal aspects of the treatment process (developing personal relationships, relapse, the influence of established patients on newcomers, and patients who leave and return) in an indigenous residential drug rehabilitation center revealed “a complex system where progression through treatment is by no means a linear process” (Chenhall 2008: 107). Bourgeois (1995) considers the struggle individuals experience in ‘going legit’ (seeking treatment) through the ethnography of a group of crack cocaine users in East Harlem and lays bare how the politics of economic exclusion alongside ethnic and class segregation work together to make treatment inaccessible.

Benton (2015) explores the notion of HIV exceptionalism largely through patient support groups, within the context of post-war Sierra Leone, whose government commanded remarkable amounts of HIV funding from global health programs despite a relatively low prevalence rate compared to neighboring countries. Especially thought-provoking, however, is Benton’s complication of traditional notions regarding HIV socialites and subjectivities, as patients do not attempt to hide a positive HIV status for fear of stigma or social ostracization, but instead strive to be legitimized through testing clinics and private medical practitioners to access treatment and resources earmarked for HIV positive patients (Benton 2015: 9). In ‘The
Face of Social Suffering, Singer (2006) challenges concepts of “American individual responsibility and privatized suffering” by following a lone drug user extensively through street life, treatment, and jail—using a single life to “bring awareness of the interplay of individual agency, social milieu, structure, and biological factors to... understand the meaning of lives in social context” (Singer 2006; 155). With this study, I also follow drug users through ED treatment, community treatment, street life, jail, and other spaces. However, I build on the awareness this sort of ethnographic following provides to create an applied intervention that hopefully helps these spaces become more cohesive for individuals to navigate successfully.

Further, there is a growing group of physician anthropologists who have the unique perspective of working from the inside out. Seth Holmes, MD, PhD, works collaboratively with other physicians and anthropologists to understand how an ethnography of health (2013) could impact public policies and perceptions, how to locate global health within the context of social medicine (2014), the integration of anthropology into clinical training (2011), and considers both the clinical gaze in healthcare delivery through the lens of social suffering and inequality in migrant and indigenous farm workers (2007; 2012; 2013). Helena Hansen, MD, PhD, is a leading voice in America’s opioid epidemic, writing about race, class, and stratified access to addiction treatment (2018), the connections of the HIV epidemic to the opioid epidemic (2019), and the re-racialization of addiction in the context of a White opioid epidemic (2019). Kim Sue, MD, PhD, embarked on a two year ethnographic journey to understand the intersections of drug use, medicine, criminality, and stigma, asserting that treating opioid dependent patients would require more than knowledge on medication, but also a “deeper understanding of structural and social inequalities, deep-seated mores and stigmas, and the punitive policing and
legislation” that combine in ways to make stand-alone medication treatment ineffective for opioid use disorder (Sue 2019: 5). Scott Stonington, MD, PhD, analyzes clinical processes and biomedical ethics (2013), ways in which patients “separate concepts of pain and suffering from Western biomedical contexts” (2015: 1388) and the metaphysical demands of dying situated in intensive care units (2011).

There is also a clinical case study series on social medicine and the importance of structural forces in clinical practice (Stonington and Holmes 2018) that considers individual patient cases where structure should drive clinical care (e.g., a patient with opioid misuse or advanced maternal age and migrant farm work). And by no means is this list comprehensive. Though many of these anthropological works go some distance towards increasing our understandings of the complexity of addiction and clinical spaces, to date hospital or clinical ethnography has not been leveraged as a tool to develop an applied intervention created to positively impact patient care. This study seeks to take that next step, capitalizing on the current wave of socially informed medicine (Farmer 2006; Hansen 2013; 2018; Holmes and Hansen 2018; Sue 2019) that sees anthropology at the forefront of both pedagogy and praxis on what influences health and well-being, how patients experience and interpret illness, the social clustering of disease, treatment, and prevention, how people heal, and the sociality of long-term medical management (Stoner 1986). This study is heavily influenced by these themes, as demonstrated in the following section, in which I outline my research questions and theoretical framing.
Research Questions and Theoretical Framing

This dissertation is organized around four key questions:

1) What are cultural divides that exist among patients, physicians, and community treatment providers around addiction, and how does emergency care relate to and contribute to addiction trajectories?

2) What are the outcomes of integrating a lived experience model of addiction into clinical care, and does this integration allow patients and providers to have an active role in acute addiction treatment and recovery during the ED encounter and after discharge?

3) What impact does the implementation of formal clinical treatment pathways for addiction have on the issue of learned helplessness for both patients and providers?

4) What are the programmatic outcomes of integrating a formal treatment pathway for addiction into acute clinical care?

These research questions and subsequent study design were intended to explore how patient/healthcare provider interactions can be viewed as three separate threads that are comprised of intersecting trajectories (described in detail below). During an acute clinical encounter for persons who use drugs (PWUD), these intersections can often lead to a breakdown in care. What can a blending of biomedicine and applied anthropology offer towards a solution?

Trajectory one focuses on formal knowledge providers and patients acquire on what addiction is supposed to be or how it is supposed to function socially and medically, and how these perceptions inform care. Most typically this would be through formal medical education and training. Trajectory two examines the movement of pharmaceutical interventions
themselves, and when, why, and how these interventions are given to patients (or not).

Trajectory three uncovers the more visceral, lived experiences that providers and patients have, and how these experiences can either lead to positive outcomes (e.g., a provider with lived experience around addiction), or negative outcomes (e.g., a patient learns from previous encounters to not expect adequate care during an ED encounter). These trajectories will be considered more deeply in Chapter Two, and all three trajectories are woven through data analysis and interpretation and reporting of findings.

**Organization of Dissertation**

This research examines the intersection of trajectories between providers and patients when seeking and providing care for opioid related crises. It presents new insights into how clinical care is delivered for addiction patients, as well as introduces a new clinical treatment pathway that renders visible the disease state of addiction. This treatment pathway builds the necessary infrastructure around OUD that allows patients to receive adequate and timely care during an emergency department encounter. The outcomes of this study suggest a path forward in integrating addiction treatment infrastructure into the ED setting as a common practice, utilizing teams comprising physicians and medical anthropologists co-creating an applied intervention. I also discuss how this study addresses common critiques in Critical Medical Anthropology (CMA) about anthropologists working within the biomedical establishment and suggest new opportunities for future research.

The dissertation is divided into seven chapters. Chapter Two provides an overview of the study’s theoretical framework, as well as a review of literature. Chapter Three focuses on
study methodology, including research questions and hypothesis, field sites, methods for data
collection and analysis, ethical considerations, and researcher positionality. Chapters Four, Five,
and Six comprise data reporting chapters, and are organized in a particular way. Chapter Four
presents an ethnographic account of what is was historically like to provide and seek care for
OUD before the BRIDGE (Building Recovery Integration for Drug Users into Emergency
Medicine) treatment pathway was implemented, for both patients and providers. Chapter Five
presents an ethnographic account of how things have changed in the ED for patients,
physicians, and community addiction treatment providers since the BRIDGE treatment pathway
was implemented. Chapter Six deals with the implementation process of the treatment
pathway, including challenges encountered, a full implementation timeline, quantitative
outcomes from patients enrolled in the pathway, and how the pathway compares to standing
hospital metrics on OUD care, as well as a section for anthropologists and other healthcare
professionals interested in building ethnographically informed treatment interventions.
Chapter Seven is a discussion of key findings, a consideration of how this research aims to
address earlier Critical Medical Anthropology (CMA) critiques of anthropologists working in
clinical spaces (Singer 1989; Scheper-Hughes 1995), how this research differs in a novel way by
creating an ethnographically informed applied intervention, as well as contributions to medical
anthropology theory, applied anthropology, addiction anthropology and biomedicine. The
chapter closes with policy recommendations and future theoretical and applied directions.
Chapter 2

Understanding the Opioid Crisis Within and Beyond Emergency Medicine Care Settings

This study considers three specific trajectories, or proposed sets of factors that may structure interactions between OUD patients, physicians, and staff, and vary depending on the location (e.g., hospital, treatment centers, city streets, and places of residence), in the context of ED-based addiction treatment. I also consider how those trajectories weave together and at times, repel each other\(^2\), during a visit to the ED for someone with opioid use disorder (OUD).

The three trajectories that have guided the research design and implementation of this study are: knowledge and perceptions, therapeutics, and experiential encounters. I describe these in detail below, taken from Raikhel and Garriott’s (2013) trajectories framework, centered on the ‘movement and method’ of addiction, and anthropological approaches to the study of addiction, which builds on Kleinman’s (1978; 1980) work on illness trajectories.

A knowledge and perception trajectory considers how formal knowledge gained about addiction moves across institutions, and how this movement weaves into a complex and shifting picture of ‘what addiction is’ to patients and providers. Knowledge and perceptions considers what formal knowledge both physicians and patients have about addiction, how that

\(^2\) If physician/patient knowledge about addiction, what role they think therapeutics should play in treatment, and what lived experiences they have had in giving/seeking care for OUD differ, it will likely lead to a negative ED encounter.
knowledge informs their cultural beliefs and perceptual framework of what addiction is and how it should be handled, as well as knowledge around treatment in the acute space. This created reality can foster negative patient encounters due to a lack of formal education and training for providers on addiction when completing medical school and residency.

A **therapeutic trajectory** tracks the pharmacological therapies available for opioid use disorder, and how these therapies are given (or not), and why. In the ED, therapeutics is often the centering trajectory, as available therapies are a marker of treatment success in biomedicine. Physicians are trained to treat acute issues (often with medications), and patients are seeking care for various issues related to OUD (often with medications). Ethnographic analysis of addiction trajectories within the context of an emergency room uncovers liminality, the in-between, ethereal spaces where different knowledge, experience, and frameworks ghost around each other, culminating in positive outcomes or devastating results.

An **experiential trajectory** considers how both patients and providers move through space and time, as well as the cultural fusing that happens during each clinical encounter. This trajectory hinges on the more visceral lived experiences around addiction that builds the experiential frameworks the physician and patient bring to the acute care encounter. Here is where you find copious miscommunications, spaces for stigma to flourish (either conscious or unconscious), and often oil-and-water interactions that rarely lead to emulsification. This is especially complex when formal knowledge gained about addiction is in direct opposition with the reality playing out during the ED encounter.

Figure 2.1 visually maps out the different trajectories, as well as the liminal spaces between each trajectory where there lies various potentialities in the overlap. Though there are
multiple trajectories, in both data analysis and this chapter, all three trajectories are present and intertwining; data and results are organized by attending to all three (Raikhel and Garriott 2013).

These trajectories are not mutually exclusive, and I discuss their intersections and overlaps in chapters to follow. However, they serve as guideposts throughout the dissertation as data and

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Figure 2.1: Addiction Trajectory Vector Model (drawn from Raikhel and Garriott 2013)
findings are presented. I draw from Raikhel and Garriott’s (2013) trajectories framework, where they outline an epistemic, therapeutic, and experiential trajectories for how to anthropologically think about the ‘movement and method’ of addiction. The only change made was to provide linguistic clarity regarding the trajectory names. I then consider how societal and institutional structures affect opioid use. The next section describes the opioid epidemic as it relates to emergency medicine, as well as what it means for the ED to be a ‘safety net’ for those in opioid crisis. Following that, I discuss the historical views of what emergency medicine is and isn’t to those working in emergency medicine in relation to drug users, and how those views and other factors can shape an unsuccessful clinical encounter. Finally, I outline the concept of healthcare as trajectory, first introduced by Kleinman (1978; 1980), and then move on to a discussion of Raikhel and Garriott’s (2013) addiction trajectories—the primary theoretical framework for this study.

**Structural Inequalities Overview**

Social and structural inequalities for drug users are ingrained in our current society; examples can include stigmatized healthcare experiences, lack of access to housing due to previous criminal arrest, inability to secure employment due to a criminal record, and more (Dressler et al 2012; Metzl and Hansen 2013; Matthews 2014; Hansen et al 2018; Bagchi 2020). If a person cannot locate employment, cannot live safely, cannot obtain essential healthcare services, and does not have the ability or finances to start mitigating these effects, the chances of successful recovery or remission from a substance use disorder fade into nonexistence. In clinical settings, racial and/or ethnic inequalities, sociodemographic factors, and common social
tropes of drug users as deviant are made highly visible during the provider-patient interaction by the cultural distance between physician and patient. This cultural discordance can often “invite dysfunctional interactions between minority patients and predominantly nonminority health professionals” (Somnath 2006: 204). Drug users could be considered similarly misunderstood in this context, as many health professionals in the ED setting are not either actively using or in recovery (or if they are, they do not self-disclose). Here, medical anthropology approaches (such as a trajectory approach proposed here) may contribute to a greater understanding of these social and cultural differences, coupled with the “interconnections and intersections of structural and behavioral factors,” often adding inadvertent complexity to clinical care, expressly in the context of the current opioid epidemic (Manderson et al. 2016: 6). A better understanding of the ways such interactions shape opioid patient care and patient-provider interactions is one of the principal aims of this dissertation.

How Structural Inequalities Shape Health (and Opioid Use)

*Drug use “offers a means to self-medicate the social misery caused by “reigning structures of social inequality” (Baer et al. 2003: 228).*

Structural violence as a framework is well established. Galtung (1969) defines this framework as “violence [that] is built into the structure and shows up as unequal power and consequently unequal life chances” (Galtung 1969: 170-171). With a particular focus on the sociality of disease, Farmer, and colleagues (2006) place specific clinical importance on understanding structural violence in direct relation to social arrangements:
“...the social arrangements that put individuals and populations in harm’s way... are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to the people affected by inequality, not the ones responsible for perpetuating it” (Farmer et al. 2006).

When seeking care in a clinical space, this social manifestation of violence can incorporate “violence to the body; structural violence; metaphoric violence; and the practice of speaking to or about patients and others in the healthcare system in ways that minimize or disrespect their full humanity” (Shapiro 2018: 1). There are similar accounts of structural violence in clinical literature, including vertical violence, defined as “yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors, which occur between two or more persons on different levels of the hierarchical system....” And horizontal violence where healthcare providers either “covertly or overtly direct their dissatisfaction inward toward each other, toward themselves, and toward those less powerful than themselves.” (Cantey 2013: 10; Griffin 2014: 257).

Although physicians daily face the biological reality that “large-scale social forces—racism, gender inequality, poverty, political violence and war, and sometimes the very policies that address them—often determine who falls ill and who has access to care”, the implementation of a structural violence framework can help move the field of medicine towards a biosocial understanding of how patients experience illness and care, “link[ing] social analysis to everyday clinical practice” (Farmer et al. 2006: 1686).
“Social and cultural differences,” coupled with the “interconnections and intersections of structural and behavioral factors”, often add inadvertent complexity to clinical care (Manderson et al., 2016). Doctors may think patients are “visiting their clinics because of symptoms and treatments, but... visits are bound up in a much larger and more fundamental social process” (Kleinman 1995: 198). Roter and Hall (2006) examine the influence of characteristics that have the potential to complicate patient-provider interactions. Four potential causes are outlined by these authors that can complicate healthcare delivery, including,

“a mutual ignorance of social or cultural norms, patient sociodemographic characteristics that providers may unintentionally be reacting to, the possibility that physician behavior may be a reflection of negative behavior the patient is displaying, and the possibility that physicians are negatively affected by stereotypes” (Roter and Hall 2006: 58).

In addition to cultural bias in medicine, Payer (1998) offers medical culture itself as a mechanism that can complicate healthcare delivery.

Understanding social context as clinically relevant to patient care dispels the notion that “each known disease is a discrete, objective, and clinically identifiable phenomenon” (Singer 2006: 50). Further, a “unique emphasis on the role of cultural marginalization in driving complex interactions” (Wilson et al. 2014: 996) moves us closer to a deeper understanding of how health disparities develop and proliferate (Singer and Romero-Daza 1999). Farmer et al. claim that it has “…long been clear that medical and public health interventions will fail if we are unable to understand the social determinants of disease” (Farmer et al. 2006, p. 1686). Re-
occurring structural issues commonly play a major role in hampering individuals who come to the ED in crisis progress towards recovery, including being uninsured, not having a primary care doctor, not having transportation, homelessness, food insecurity, felony criminal records, or chronic unemployment.

Any of these factors would be challenging to navigate; it becomes a real gauntlet when they start interacting with one another. For example, once someone has acquired a felony criminal record, their housing and employment prospects are immediately (and often irrevocably) altered. The most common occupations that one can obtain with a felony record include restaurants, construction, factories, or domestic work. Such positions do not typically include sick day, insurance benefits, or a retirement plan. Often, people in these positions are forced to work, even if gravely ill, to make ends meet and care for their families. Manual labor jobs are also very physically demanding, and it is exceedingly common for people in the absence of adequate time off or access to healthcare to begin managing physical pain and sickness with opioids (Case and Deaton 2020). The likelihood of this exponentially increases if someone was previously treated with an opioid for an injury. So without sick days, health insurance, or the ability to take time off, people often wait until their health has deteriorated to a point that prevents them from functioning, resulting in an emergency room visit. The next section will consider the opioid epidemic in relation to emergency medicine, as well as what it means to be a safety net hospital that provides a large portion of annual care to structurally vulnerable patients.
The Opioid Epidemic in Relation to Emergency Medicine: The Hospital as Safety Net

According to the Institute of Medicine, a health care safety net:

“...comprises hospitals and other providers that organize and deliver a significant level of health care and other health-related services to patients with no insurance or with Medicaid. Often referred to as providers of last resort, safety-net hospitals (SNHs) have historically assumed a major role in the provision of comprehensive services to medically and socially vulnerable populations (Lewin et al 2000; Lukas et al 2016; Sutton et al 2016).”

My field site for this study is recognized as a “safety net hospital.” From 2016-2017, this hospital saw an 18% increase in the number of opioid use-related emergency department visits (Schorsch 2020), and in general “nearly half of all ED visits in the US are categorized as relating to substance use disorders” (Hawk and D’Onofrio 2018: 13). Patients with opioid use disorder (OUD) are consistently at an increased risk of adverse health outcomes versus non-OUD patients. Patients with OUD frequently seek out the emergency department (ED) for healthcare, either for issues directly related to OUD, comorbidities, or acute illnesses and trauma (D’Onofrio et al. 2015). OUD is now being supported by many as a chronic relapsing disorder “similar to asthma, hypertension, and diabetes” (WHO 2009; Courtwright 2010; Gustin et al. 2015) and recognition that opioid addiction can be reframed and treated as opioid use disorder is growing, especially in emergency medicine (Parker et al. 2019; Samuels et al. 2019; Dasgupta et al. 2018; D’Onofrio et al. 2018). Even so, there is still little infrastructure in place to address OUD-related concerns acutely. A significant reason for this absence of infrastructure
could be the result of acute treatment of OUD historically falling outside the scope of practice for ED providers (Im et al. 2018).

**What Emergency Medicine "is and isn't"**

Within a traditional approach to biomedical care, emergency medicine has not been regarded as a specialty that dealt with addiction. If someone was struggling with addiction, the ED was not the place to find care. There were multiple barriers to the integration of addiction treatment in the ED space, “including competing priorities, inadequate training in addiction medicine, and stigma” (Hawk and D’Onofrio 2018:13). Here we begin to see the first hints of the importance of trajectory—physicians and other caregivers in a clinical setting are inducted into the culture of medicine by their formal training and lived experiences, which can produce significant variation in the care that is delivered. Clinical interventions are directly affected by what has been taught, and the direct influence of the knowledge of peers and colleagues formulates what in the providers mind is the right thing for the patient (Payer 1988). Hahn (1995) also characterizes biomedicine as a cultural system, comprised of

“[not only] the complex social and cultural arrangements of physicians who diagnose and treat disease, but also of diverse personnel and institutions of care, extensive industries, programs of health insurance, research, and multiple government and private agencies” (Hahn 1995: 131).

These complex cultural and social arrangements are examined in this dissertation ethnographically by considering the co-creation of cultural practices between patients and caregivers, taking place over and over again, with each patient encounter. The acute care
interaction between a patient and physician uncovers a key access point for an applied intervention.

Kleinman (1981) posits that cultural factors shape health-related beliefs, behaviors, and values, and offers cultural explanatory models as a determination of who seeks medical attention, for what conditions, when, and with what results (Kleinman, Eisenberg and Good 1978; Kleinman 1981; Hahn 1995). This well-known model is still useful for understanding the differing expectations patients and physicians have about how the clinical encounter is going to go when providing/seeking care for OUD. Patients and providers both have a model that encapsulates the medical visit, comprised of:

1. An explanation of the cause(s) of a sickness,
2. A description of precipitating circumstances and first symptoms,
3. An explanation of the physiology of the sickness,
4. An outline of the course of the sickness and appropriate patient behavior,

During the clinical encounter, if the patient explanatory model is variable, illogical, or otherwise in opposition of the physician’s explanatory model (as is often the case with drug using patients), it is regularly dismissed without a negotiated understanding of how social complexities and lack of cultural understanding are driving the discrepancy. For example, a physician’s model for providing care for OUD, which is not considered an acute crisis, is developed throughout medical training and outlines what steps to take (e.g., observe for acute distress, stabilize symptoms like nausea with various medications, and have social work refer the patient to treatment somewhere). The patient’s explanatory model is that they are
experiencing an acute crisis, and often do not understand why the physician will not “do something for them” by providing care. Here, the discrepancy lies in what is considered acute, and what is within the bounds of emergency medicine to address. Most of the time, the acuity the patient is experiencing stems from social and structural complexities that emergency medicine has historically been ill-equipped to address. Further, Farmer (1998) focuses on disease itself as a site of complexity, claiming that “disease visibility is embedded in social context” therefore diseases that “rank among the poor or dis-empowered” such as HIV, addiction, or depression that come with entrenched social stigmas, then act as agents themselves to make providers see a patient as medically complex (Farmer 1998: 103).

The Medically Complex Patient

Clinically, there is a systematized importance placed on patient complexity that can either overtly or covertly set the tone for how a clinical encounter will go before a doctor ever set’s foot in a patient’s room. A patient is categorized as medically complex if there is a chronic illness, history of non-compliance with medical treatment, mental/behavioral issues, essentially any structurally complex issue that would make successful medical intervention difficult. There exist assorted social determinant clinical screening tools to assess health disparities such as “food insecurity, intimate partner violence, or quality of housing” (Davidson and McGinn 2019: 1037). However, a myriad of factors, including ‘poverty, racial and ethnic inequities and lack of preventative care’ are also determinants that can lead to poor health (Anderson et al. 2016: 487). Stafford and colleagues (2007) suggest a conceptual framework to “achieve congruence” between patient and physician, labeled the Vector Model of Complexity to address social
determinants of health (see appendix B). Though there are six subsections of complexity, only the biological/genetic axis is underlined because “a patients complexity arises from different axes, but physicians often focus solely on the biological axis” Safford et al. 2007: 384). Also not included in this model are the complexities that occur at an interactional level between patients seeking care and healthcare providers offering cure. This is a gap addressed by this study.

As stated above, explanatory models of sickness occur (Kleinman, Eisenberg, and Good 1978), and there are many well-documented anthropological accounts of the breakdowns that can transpire when the Western biomedical worldviews of providers meet the social and cultural realities of patients (Foster 1980; Baer et al. 1989; O’Conner 1994; Hahn 1995; Earp et al. 2002; Baer et al. 2003; Matthews 2004; Lende 2005; Mendenhall et al. 2012; Scherz 2018; Mulligan and Castañeda 2018; Bagchi 2020). Often there are “major conceptual differences” between biomedical interpretations and patient understanding “when they make no cognitive sense across the cultural gap” (O’Connor 1994; 95).

In any health care setting, a blending of three cultures simultaneously transpires: the patients’, the providers’, and the health care organizations. To establish a functioning relationship that occurs in real time, while simultaneously integrating effective cultural sensitivity, a fusion of these three cultures must occur in a significant way for each to understand the interrelationship of the health care situation (Ohlinger 2005). One key place for applying anthropology to an intervention that can form a functioning relationship between physicians and patients is in ethnographically discovering what factors lead to an unsuccessful clinical encounter.
Factors that Shape Unsuccessful Clinical Encounters According to Anthropological Scholarship

Anthropologists such as Nancy Scheper-Hughes (Scheper-Hughes 2008), Paul Farmer (Farmer 2002; 2008), Merrill Singer (Singer 2004; 2017), Angela Garcia (Garcia 2010), and Helena Hansen (Hansen et al. 2010) have extensively chronicled the deleterious effects that lack of access to care, stigma, and racial inequality can have when attempting to access the healthcare system. These factors also often work in tandem to exacerbate already-present inequalities to further widen the gap between sickness and health (Henderson 2018).

Stigmatized disease states such as HIV or racial health disparities can also subconsciously affect the way a physician sees a patient; whether intentionally or unintentionally, physicians are negatively affected by stereotypes. The assumptions that physicians make upon patient presentation regarding their character, affect, emotion level, behavioral displays, or potential level of understanding all “have clear implications” for the care that is then given (Payer 1988).

Racial or ethnic inequalities, sociodemographic dissimilarity, moral incongruence—these distinctions are made highly visible during the provider-patient interaction by the cultural and identity-related distances between physician and patient, and this cultural discordance can often “invite dysfunctional interactions between minority patients and predominantly nonminority health professionals” (Somnath 2006: 204). I argue, however, that the path to tackling these significant issues starts at the beginning of the patient-provider encounter with the initial communication or first impression. Here, I want to focus on non-verbal communication, as medical terminology can often be confusing and opaque, so patients often lean on this style of communicating to determine provider sincerity—whether the doctor actually cares about them and is there to help (or not).
Nonverbal communication, what Hall (1976) refers to as low context communication, is the ability to understand the “nonverbal expressions and cues embedded in verbal transactions... smiles, nods of agreement, grimaces of pain... all give context to and enhance the meaning of spoken words” (Roter and Hall 2006:3). It is well understood that how patients experience and understand medical communication impacts the effectiveness of the care they receive. A patient’s motivation (or lack thereof) to adhere to treatment protocols or medication regimes may hinge on the quality of communication during the doctor visit. For instance, rates of severe diabetes complications in patients of doctors who rate high on empathy is almost half that of patients with low-empathy doctors—which “is comparable to the benefits seen with the most intensive medical therapy for diabetes” (Ofri 2010). Nonverbal communications are also indispensable to the patient encounter.

A loss of low context communication results in a perceived loss of empathy, where the emotions and concerns of the patient are not objectively helpful to diagnosis and treatment. There is a tangible distinction between providing care, and the act of caring. Intermittently, physicians may become so swept up in the technical and biomedical processes for providing care, that they may forget how important it is to care. In 1927, Francis Peabody, M.D., wrote in an article for the journal of the American Medical Association that:

“*The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine—or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients*” (Peabody 1927).
Over eight decades later in an opinion piece for The Atlantic, O’Rourke (2014) corroborates Peabody’s assertion, and posits that this lack of caring may be a reason it has become so difficult for doctors and patients to communicate with each other:

“… [ours is a] technologically proficient but emotionally deficient and inconsistent medical system that is best at treating acute, not chronic, problems: for every instance of expert treatment, skilled surgery, or innovative problem-solving, there are countless cases of substandard care, overlooked diagnoses… even outright antagonism between doctor and patient. For a system that invokes “patient-centered care” as a mantra, modern medicine is startlingly inattentive—at times actively indifferent—to patients’ needs.”

Bishop (2007) argues that patients are missing a “more empathetic practitioner–patient relationship, a better consideration of individual needs, more participation in decision making… and a better inclusion of psycho-social and spiritual needs” (Bishop et al. 2007: 267). Heusser and colleagues (2012) propose that directly accounting for “physical, organismic, psychic, spiritual and social aspects in medical theory and practice as well as in professional education” may contribute to improving communication with and benefit for patients in a more humanistic form, which is analogous to frequently expressed patient concerns (Heusser et al. 2012: 459). Moreover, there is a growing body of work in healthcare around doctors turned patient; one physicians’ reflexivity after a medical crisis stated, “If being ill has taught me anything about being a doctor it is the importance of seeing a patient as a [holistic] person and not merely a condition or disease sat in a hospital bed” (Tomlinson 2014: 348). Here, the integration of an
anthropologically-informed intervention within the clinical space that focuses on holistic patient care and the value of bodily lived experiences may create a foundation of care that simultaneously addresses structural vulnerabilities and stigma. This nuanced approach to care could potentially enhance patient benefit from and satisfaction towards treatment.

Framing OUD as a chronic relapsing disorder (along with a shifting focus in perceptions of the disease, political will, and funding) may have begun to change attitudes, making space in biomedicine for a treatment mechanism (e.g., something ‘do to’ for the patient). The keynote speech for the 2018 Society of Academic Emergency Medicine conference was given by Gail D’Onofrio of Yale University, in which she stated that “the detection and initiation of treatment for chronic and relapsing medical conditions... is standard ED practice”:

Due to the profound neurobiological and behavioral changes that characterize opioid dependence, it is likely that a more potent intervention, such as ED-initiated treatment including buprenorphine, will be needed to produce optimal outcomes. This model is similar to other chronic medical conditions such as hypertension, diabetes, and asthma in which ED clinicians initiate or restart treatment (D’Onofrio et al 2015; 2018).

In the past, the only real form of treatment traditionally available for patients in acute withdrawal was mild medications for peripheral symptoms\(^3\) and a general referral to addiction treatment services. However, D’Onofrio pioneered offering medication-based OUD treatment in the ED with a 2015 randomized clinical trial, which involved integrating ED-based stabilization

\(^3\) Medications are often dispensed solely to treat peripheral symptoms of withdrawal (e.g., Zofran for nausea)
of withdrawal due to opioid use disorder (OUD) with buprenorphine\(^4\) as a choice for treatment (along with offering more traditional medication and a referral to addiction services). This clinical trial was the first of its kind to gauge the efficacy of treating withdrawal using medication for opioid use disorder (MOUD) in the ED. MOUD is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders, which has been positioned as the “gold standard” treatment approach in medicine (see for example D’Onofrio et al. 2015; Mittal et al. 2017; Michaelson 2018).

However, biomedical, public health experts are “increasingly recognizing the failure of clinical trials type research to answer all questions and solve all ills” (Sobo 2011: 25). The synergy between biomedical disease and the social condition is something already known in the field of anthropology (Browner 1999; Baer et al. 2003; Campbell 2007; Singer 2012). This acknowledgment that we need more than clinical trials to care for structurally vulnerable patients creates an opportunity for anthropology to work with biomedical practitioners as a team of equals. This partnership, which is demonstrated in this study, has the potential to co-create an equilibrium between structural complexity and biological disease by building ethnographically informed treatment interventions that focus on “whole patient” care, which comprises a team approach to treatment. This approach is especially critical in such a

\(^4\) Buprenorphine is a medication used for the treatment of OUD, which may allow for less euphoria and physical dependence, lower potential for misuse, a ceiling on opioid effects, and relatively mild withdrawal profile. The administration of this medication suppresses symptoms of opioid withdrawal, decreases cravings, blocks the effects of other opioids, and could reduce illicit use and help patients stay in treatment (Walsh and Eissenberg 2003).
vulnerable population, where a team of specialists and caretakers are often needed to ensure a patient will thrive (TEDMED 2020).

Admittedly, while whole patient care is the goal, it can be very difficult to execute in the ED for patients in the context of addiction. Seeking and/or receiving treatment from multiple doctors is common, and prohibitive privacy laws can prevent quick access to health information. It can be challenging for physicians to know what treatments the patient is receiving or what medication they may be on. For example, a patient may be on an opioid or medication for OUD and need that medication emergently because they ran out or their medication was stolen. If it cannot be verified that the patient has ‘legitimately’ received a prescription for this medication and they are still under a physician’s care, it’s most likely that medication is not going to be given. Couple this with a lack of willingness on the patients’ part to divulge pertinent health information or substance use due to perceived stigma, or previous negative healthcare experiences, and the difficulty quickly grows. Additionally, addressing the “social support systems, current economic situation, spiritual beliefs, cultural background, and values” to build the trust necessary for this patient population to feel comfortable in the limited time an ED provider must interact with patients is a formidable task (DerSarkissian et al. 2018).

A deeper understanding is needed to unravel worries physicians are confronted with when providing care to drug-using patients, such as physician fear of deception, “legitimacy” of patient requests, fears of being manipulated into inappropriate prescribing, and previous negative experiences with drug using patients (O Merrill et al. 2005: 331). To truly understand patient and provider experiences, especially in determining if the care received had positive, negative, or no effect on downstream patient outcomes, a framework is needed which allows
for tracing connections between what patients experience in clinical spaces and their lived experiences, both before and after the clinical encounter. Such encounters are a key area explored by this research. Based on previous research and participant observation in the study site, I think there are clinically significant differences between the life of the imagined patient that a healthcare institution is designed to serve and a patient’s actual life. This will be especially apparent in the following section through a discussion of a sense of learned helplessness expressed to me by physicians and documented through participant observation in providing acute care, and illness trajectories of both patients and diseases themselves.

Examining Learned Helplessness and Addiction Care in the Emergency Room

A key component to an anthropology of addiction which this study seeks to create is the examination of the concept of “learned helplessness” in those perceived to be in power (e.g., physicians). This examination may help to clarify why barriers and miscommunication so frequently occur between a patient and provider during the ED encounter. These barriers often result in a provider not knowing how to care for an OUD patient, and that patient also not willing to be cared for. The concept of patient learned helplessness is routinely a part of behavioral health clinical education, teaching behavioral health providers to conduct motivational interviewing⁵ to mitigate a persons’ perceived lack of will or understanding to help themselves. Based on participant observation in the ED setting, I argue that this phenomenon occurs both on the part of the patient and the provider. These experiences are detailed in

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⁵ Motivational interviewing is a counseling method that involves enhancing a patient’s motivation to change by means of four guiding principles, represented by the acronym RULE: Resist the righting reflex; Understand the patient’s own motivations; Listen with empathy; and Empower the patient (Lubman et al 2012).
chapter four, but I suggest here that it may be beneficial to explore this assumption further to uncover new ways for both patients and providers to co-create sustained and meaningful care. I was not able to find a specific instance of a theory of learned helplessness being utilized by anthropologists to consider how the ED encounter is co-created during care for social disease states. The concept is described in depth in the following section, along with the need to understand the significance of learned helplessness in relation to a specific health care problem.

**Learned Helplessness in Relation to Emergency Medicine**

The utilization of learned helplessness as a concept for understanding behavior provides an explanation for some human behaviors that might seem odd or counterproductive, and this understanding may provide new sites of intervention to remove or reduce the negative impacts barriers to care have during the emergency encounter. Here, emphasis exists on the *learned* part of learned helplessness, as it is not an innate trait. In 1975, Seligman and colleagues proposed that subjecting participants to situations in which they have no control results in three deficits: motivational, cognitive, and emotional (Abramson et al. 1978). The cognitive deficit refers to the idea that their circumstances are uncontrollable. The motivational deficit refers to the lack of response to potential methods of escaping a negative situation. Finally, the emotional deficit refers to the depressed state that arises when the person is in a negative situation that they feel is not under their control.

Seligman et al. further identified two general types of learned helplessness: universal and personal (Seligman 2011). Universal helplessness is a sense of helplessness in which there
is a resigned belief that it is not possible to alleviate pain or discomfort. Conversely, personal helplessness is a more localized sense of helplessness. The person may believe that others have the ability to find a solution to avoid pain or discomfort, but that they, personally, are incapable of finding a solution (Abramson et al. 1978). Considering both forms of learned helplessness is important when thinking about ED encounters more broadly, as I have observed a greater degree of universal helplessness on behalf of providers, and a more personal sense of helplessness on behalf of patients.

Learned helplessness is an important aspect of the broader framework of anthropological addiction trajectories employed in this study, to answer long-standing questions surrounding the structural forces that comprise social disease states. Some of these enduring questions that are often asked: Why can patients not just “beat their addictions?”; Why do patients with addiction not listen to medical advice?; and Why do patients with addiction come to the emergency room again and again for care? A novel contribution of this study is to also consider the effects of learned helplessness to understand how physicians interact with patients suffering from addiction, and why they feel so ill-equipped to provide acute care for this disease. Drawn from psychology, this concept is applied as an explanation for why patients make poor choices regarding their health. Examples of this can be seen in the patient who chooses to smoke after multiple failed quit attempts, accepting that they will always be a smoker. Or a victim of domestic violence who chooses to stay in an abusive situation despite multiple ED visits. Or the patient who chooses to remain overweight despite developing several weight-related health complications.
These examples mirror the ‘choice versus no choice’ binary seen in relation to people who use drugs. Further, mobilizing learned helplessness in this way increases power imbalances between the medically complex patient, and the exasperated provider. There is also a marked lack of complexity when the theory is used in this way, that does not account for similar issues occurring in those tasked to provide care. Learned helplessness in this context, which considers those being cared for and those providing care, can then be viewed, and understood as a dynamic concept, which moves fluidly through each acute care encounter between both patient and physician due to life experience, enculturation, and differing expectations. A clinically situated ethnography to understand the lived experience of both patient and provider opens the possibility of creating care pathways for addiction treatment that mitigate the effects of learned helplessness by empowering physicians with clinical tools and educational training, and empowering patients in seeking treatment for addiction.

Healthcare as Trajectory

Explanatory Models of Illness

The earlier section on explanatory models focused on physician/patient interactions. This section will consider the explanatory models of disease. This is an important distinction in this study, as addiction is often not considered a disease process, which can lead to patients receiving poor care. Disease pathologies that “make up the medical model of ill-health, such as diabetes or tuberculosis can be specifically identified and described by reference to certain biological, chemical or other evidence” does not explain why two patients may have the same pathology, but the way that pathology is presented and experienced emerges in completely
different ways (Helman 1981: 548). Arthur Kleinman’s seminal work on study of illness and
disease is reflected in his scholarship of patient explanatory models of illness, which considers
how sickness is culturally produced, and in what ways clinical care can demonstrate the cultural
variation in the experiences, diagnosis, and treatment of illness (Manderson et al. 2016: 5;
Kleinman 1980; Kleinman et al. 1978). These explanatory models:

(a) construct illness as a psychosocial experience; (b) establish general criteria suitable
for guiding the health care seeking process and assessing the potential efficacy of
different treatment approaches; (c) managing illness episodes through communicative
operations such as labeling and explaining; (d) providing healing activities (therapeutic
intervention, supportive care); and (e) managing therapeutic outcomes (including
chronic illness and death) (Kleinman 1980:71-72).

Kleinman writes that a person’s explanatory model [both patient and provider] has a diagnostic
importance “as an instrument for studying the healing process and clinical transactions
between patients and practitioners”, a didactic importance “as a framework for teaching
practitioners the meaning of illness and the limitations of the biomedical model for clinical
practice” and that explanatory models have a particular clinical significance for:

“...determining the priorities and concerns of patients, exploring problems of
noncompliance, negotiating therapeutic alliances with patients (especially when they are
ethnically distinct), and choosing and evaluating treatments and methods for managing
One significant limitation of the biomedical model is the consideration of disease as a separate entity from the social contexts in which disease is found. It is also critical to understand how social environments dictate health (Singer 2004). Good (1994) further underscores the important role of culture in the experience of illness, asserting that disease is a cultural process, which should be understood not as a separate and individualized entity to be cured, but as a “unit for grouping and understanding why individuals get sick” (53). One way to accomplish this is the analysis of social environments as a determination of health. How health is impacted by social environments is referred to as social determinants of health (SDH), which are defined as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (ODPHP 2020).

This encompasses a broad range of determinants, comprising lack of access to transportation, unclean air and water, unsafe housing, lack of access to education, chronic unemployment, racism, violence, and the list goes on. Put simply, the greater the access, and the higher the social position, the better the health (Marmot et al. 1978). Focusing on “the causes of the cause” Marmot and Wilkinson’s (1999) SDH research was an “early attempt to bring together much of the information on the broad footprint of the social environment on health” (Kaplan 2006: 376). It is clear that social environments have “compounding effects on physical and psychological health” but these determinants tangle together in complex ways that compound sickness (Manderson et al. 2016). A focus on particular social environments can determine health in a population, which can then be expanded to recognize how multiple social environmental realities connect in ways that can form complex and chronic health issues.
Illness Trajectories

Straub and colleagues (1982) coined the term illness trajectory to refer not only to “the physiological unfolding of a patient’s disease but to the total organization of work done over the course of illness plus the impact on those involved with that work and its organization” (257). Trajectory work, then, deals with illness, the course of illness, managing the illness, accompanied by the management all of the interrelationships involved in these undertakings (Goffman 1963). This framework also aligns with common medical research where participant outcomes, and possibly treatments or exposures, are collected at multiple follow-up times (e.g., following HIV patients over time to assess immune status and disease burden) (Locascio 2011). For more examples of past social science literature that clinically engages with an illness trajectory framework, see Strauss et al. 1984; Sankar 1986; Kaufman 1986; Corbin and Strauss 1987; Singer 1987; Kaufman and Becker 1991; and Wiener and Dodd 1993.

In a recent ethnography on the intersections of clinical care and the criminal justice system in the lives of drug users in Boston, Sue (2019) exemplifies the importance of trajectories by not only interacting with patients in the clinic where she practiced, but also “…[following] them as they sought treatment in the community, as they tried to care for themselves in the prison and jail and after release, and as they cycled in and out of various regimes of care intermingled with punishment” (5). The illness trajectories model has also been highly influential in qualitative health research, particularly in clinically applied studies in mental health seeking to understand “when, where, and how to intervene” in order to achieve improved health outcomes” (Raikhel and Garriott 2013: 9). Hser et al. (2007) builds on the
concept of illness trajectories within the context of addiction, offering a life course perspective which

“...offers an organizing framework for classifying varying drug use trajectories, identifying critical events and factors contributing to the persistence or change in drug use, analytically ordering events that occur during the life span, and determining contributory relationships” (515).

Anthropologically informed literature on drug-use trajectories underscores that norms, role expectations, and understandings of pathology are not only culturally determined but also differential across the local conceptualizations of the life-course (Topper 1974; Feldman 1977; Bourgois 1995; Nichter et al. 2004, Hser et al. 2007; Raikhel and Garriott 2013).

Addiction Trajectories

The guiding theoretical framework for this research is what Raikhel and Garriott (2013) refer to as addiction trajectories, which is useful in examining addiction across time, place, institutions, and individual lives. Table 2.1 illustrates three separate trajectories followed in this research (as discussed previously), and I aim to demonstrate the critical need to ethnographically understand how trajectories both repel and intertwine in order to create a successful applied intervention focused on the acute care of addiction.
Table 2.1: Addiction Trajectory’s and Associated Research Aim

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<thead>
<tr>
<th>Addiction Trajectory</th>
<th>Research Aim</th>
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<tbody>
<tr>
<td>Knowledge and Perception Trajectory</td>
<td>Tracking biomedical knowledge about addiction (historical and gained), and shifting perceptions on addiction that inform both patient and provider models of illness</td>
</tr>
<tr>
<td>Therapeutic Trajectory</td>
<td>Tracking the non-linear movement of pharmaceutical interventions for opioid use disorder across institutions</td>
</tr>
<tr>
<td>Experiential Trajectory</td>
<td>Tracking the non-linear movement of patient and provider through space and time</td>
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Lende (2012) articulates that because modern societies “... often demonize [drug use], confining it to marginalized places of the social map, drug cues and drug availabilities come packaged together in specific environments (349). Ergo, “inadequate funding for in-patient treatment programs, the lack of follow-up services for those trying to recover, the difficulties [of] finding gainful employment in the licit market, and resistance to the expansion of [pharmaceutical] maintenance for those who want to address their addiction through therapeutic measures” all frequently coalesce into health crises, in which emergency rooms are ground zero for care. In this sense, working in a teaching hospital, which disproportionately provides care to marginalized populations, is a useful field site to analyze addiction trajectories. Especially in analyzing the paradoxical outcomes patients have when seeking emergency care for addiction.

Contradictions abound for people who use drugs when trying to seek treatment (for anything) within the healthcare system. Dozens of individual stories often melt into the same distressing encounter, encapsulated by stigma, social ostracization, and inadequate access to care. The predominant social narrative is that drug users are “symbols of danger, contamination, and evil, posing threats to ideals of safety, virtue, upright living, and public morality (Sue 2019: 13). The unspoken message is that to participate in normative society, a
drug user must “get clean” before re-entry is allowed to happen. As humans are inherently social creatures, it often becomes of utmost importance to pursue this social prescription, especially if drug users have been forcibly separated from children, become homeless, or are unable to secure employment. Seeking help from another requires a certain level of vulnerability, and when a drug user has a negative experience with the inability to access care, that vulnerability hardens into rock hard resolve to never engage with the healthcare system again.

These demonstrated gaps in understanding drug use subculture, and the importance of lived experience becomes critical in the development of an addiction trajectory framework. Payer (1988: 9) claims that “three elements characterize the essence of the clinical transaction between patient and physician: technology, caring, and values.” It is here that a breakdown often occurs; often treatment providers values do not align with a drug user, and from this, a mutual distrust crystalizes, where physicians “fear deception, inconsistency, and behavioral problems” and the patients already “sensitive to the possibility of poor medical care often interpret physician inconsistency or hospital inefficiency as intentional mistreatment” (O Merrill et al. 2002: 327). However, this breakdown often occurs before the physician ever enters the patients’ room. Preconceived notions that affect care may subconsciously arise at the first glance of the chart, born out of medical training that often conditions physicians to view reports of illness as subjective, and untreatable in an acute setting due to the absence of observable biological pathology. At this nexus of disease and illness, where communication often breaks down, there exists a window for anthropology to have a critical engagement with the biological sciences.
Many ethnographies aim to problematize both social and academic imagery of the *urban drug user*, comprised of “psychopathology and the sociology of deviance,” however, anthropologists have “often ignored the wider social context that fosters drug use and addiction, a core issue among... medical anthropologists studying drug use” (Singer 2012: 1750). In clinical spaces, psychopathology and deviance regarding drug-using patients is often the dominant narrative, therefore the benefits of conducting ethnography in tandem with physicians in hospital spaces sheds light on subjective experience and situates this study as one focused on the integration of knowledge on addiction into treatment settings to potentially work to combat the positivist reductionism often found in clinical (particularly acute) settings.

**Moving Beyond “Usual Care”**

Singer highlights a common thread in medical anthropology of failing to situate the micro behaviors of individual actors into the larger systems of meaning that comprise social structures, which, as a result, reduces medical anthropology to “an examination of the cultural determinants of illness, curing, and resistance to biomedicine with little consideration of “the importance of the social formations in which ‘cultural factors’ occur” (Gruenbaum 1985: 48; Singer 1989). Further, a critique born of medical sociology has also migrated to medical anthropology in that there is a *medicalization* that occurs where the anthropologist takes on roles to develop both theories and interventions that “reinforce the medical monopoly” (Pflanz 1983: 568).

Following Singer, I argue, however, that integration into *a clinically reproduced and commodified reality* lies a capacity for a critique of medicine (Singer 1989: 1194). Further, the
grounding of this study in the microlevel cultural exchanges of patients and physicians centered on drug treatment helps to contextualize larger social structures and behaviors around drug use and addiction. To craft solutions to the pressing problems of addiction, it is critical to consider research that moves past the false dichotomy of addiction as biomedical brain disease/chemical imbalance versus a socially constructed illness. Moving past this dichotomy utilizing an addiction trajectories framework within the context of a biomedical care system serves to fill a gap both in medical anthropology and addiction medicine literature that tends to have a granular focus either on social marginalization and lack of access to care or the physiological consequences of drug use in relation to biomedical treatment. Ethnography in this context allows for the bridging of clinical and patient experiences, a greater understanding of physician/patient interactions during acute care for addiction related complications, and a deeper integration of critical medical anthropology into clinical spaces.

Further, this study is a means to think through earlier critiques of Critical Medical Anthropology (Lock and Scheper-Hughes 1987; Foucault 1989; Turner 1992; Scheper-Hughes 2000; Scheper-Hughes 2003; Farmer 2003; Castro and Singer 2004; Singer and Baer 2008; Patryna 2009), such as the tendency of health sciences to naturalize the process of health and illness, or anthropologists working in healthcare settings becoming absorbed by and acquiescent of reigning structures of power and inequality, in such a way that grapples with the ethics of anthropology working side by side with biomedicine. In this study, there is potential for a more nuanced focus on individual suffering coupled with provider experiences, creating a blended and more contextualized view of the social and structural determinants that
complicate providing care for hidden patient populations; those suffering from chronic
conditions unable to be resolved in an acute encounter.

This dissertation examines the potential of medical anthropologists working in tandem
with biomedical professionals as equals to build treatment pathways which serve as a cultural
bridge between physicians and patients. Bridges that allow for the biomedical treatment of
disease, while also making space to address the social and structural elucidations of illness. This
unique hybridization may also provide space to create new clinically applied interventions to
improve biomedical approaches to clinical encounters, more robust medical education around
socially vulnerable diseases, and a healthcare system altered to address gaps more broadly in
care for structurally vulnerable patients.
CHAPTER 3
Methodology

The beauty of ethnography is “its capacity, through storytelling, to make sense of suffering as a social experience” and to provide contextualization by considering ways in which “social structures and ideologies shape the likelihood and impact of infections, injuries, bodily rupture and disease, chronic conditions and disability, treatment and care, and social repair and death” (Manderson 2019: ix [in Reyes-Foster 2019]. This dissertation utilizes ethnography to address a missed opportunity to date regarding the “very little ethnographic research [available] about …stakeholders in complex medical contexts, e.g., of those exclusive of the patient, of clinicians and their teams, or other kinds of hospital workers” with a specific focus on the treatment of patients with opioid use disorder (Long et al. 2008: 73). A deeper understanding of the “complexity of multiple perspectives has much to offer both medicine and anthropology” (Long et al.2008: 76). In this chapter I describe my ethnographic methods for data collection and analysis throughout the dissertation research process.

Ethnography and Lived Experience in Clinical Spaces

The use of ethnography in clinical spaces has the potential to translate lived experience into clinical relevancy. Moreover, I suggest that it may also be useful to blur the false dichotomy between medical disease and social illness or suffering, merging the two into one cohesive treatment model that compassionately addresses the biological and social complications of
drug addiction. Ethnographic research in the clinical space on the contours of addiction using a trajectories model could create “a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application” (Kleinman and Eisenberg 1978: 251). A focus on knowledge gained by experience as clinically relevant to the treatment of addiction could also facilitate a removal of the barriers often witnessed between providers and drug users during the clinical encounter. Ethnography allows for the addition of nuance and complexity in hidden populations of patients with a substance use disorder, whereas otherwise drug using individuals may be relegated to a data point or statistic. A blending of anthropological methodology with biomedical caregiving can also create a deeper understanding of social pathologies (Colson and Selby 1974: 253). These are aims that informed my research design and to which I will return throughout the dissertation in chapters to follow.


This study employed a mixed methodology, including the collection and analysis of quantitative electronic health record and patient visit data, as well as ethnographic data collection through interviewing, participant observation, and clinical shadowing. A blending of these methodologies offers a clear way to approach the clinical setting as quantitative metrics are important measures of clinical treatment intervention ‘successes’ and qualitative methods serve to illuminate hidden populations—patients that have always been there and will continue to be there but are hidden from view by current treatment structures that do not reflect the social implications of disease. Participant observation and clinical shadowing was carried out to
document patient-physician and healthcare provider interactions and interventions of care, as well as to understand the culture of emergency care in relation to social diseases, and how access to treatment is impacted by this cultural exchange between patient and provider. Additionally, in order to more deeply understand patient and provider experiences when giving and seeking care for opioid use, open-ended and semi-structured interviews were conducted with a selection of physicians, BRIDGE program participants, and community stakeholders to highlight both similarities and particularities in the trajectory of addiction, difficulties and successes in providing care for patients with addiction, and what role lived experiences play when seeking treatment in the healthcare system.

In this chapter, I present multiple methods for conducting anthropological work in clinical settings. By moving ethically and reflexively through the clinical space, I aim to highlight the value of anthropology as a means to craft applied interventions to address the pressing problems of medicine, with the current opioid epidemic taking a center stage. This dissertation argues that a critically applied medical anthropology may bridge divides between social science and medicine in the clinical space, developing a patient-centric structural gaze to both complement and shift the clinical gaze of physicians and medical staff that often becomes hyper-focused on a priori disease states during the patient encounter. Such an approach moves us from “pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions” (Metzl and Hansen 2014: 126).
Study Logistics: IRB, Sites, and Research Timeline

The timeline for this research is separated into two streams. In the first stream, quantitative data collection of patient health information and treatment outcomes data started when the BRIDGE program began during the first week of September 2018. This data was collected in an operational capacity, to run the program, and link patients to care. During the second stream, I received approval from the University of South Florida’s Institutional Review Board (IRB) during the summer of 2021 after which I began conducting interviews, as well as selected a portion of BRIDGE patients for quantitative analysis (see below). Data collection concluded at the end of September 2021. This study has two IRB approvals for evaluation purposes of different components of the BRIDGE program, including overall quality of care delivered via the program, and a separate component that offers co-located treatment for patients with OUD and Hepatitis C (HCV). Memorandums of understanding (MOU’s) were created between the hospital as the primary field site and both substance use treatment centers that I worked directly with as secondary field sites to link patients to care. These memorandums guarantee confidentiality of patients and physicians participating in the BRIDGE program and follow strict HIPAA guidelines.

I carried out nearly 1500 hours of participant observation at my field sites, and that time spent in these spaces yielded hundreds of informal interviews that were recorded in field notes. I conducted 30 semi-structured interviews (see table 3.3) which I recorded with a digital recorder and utilized dedicated transcription software to transcribe. Unstructured interviews were recorded from memory in field notes directly after the interview when possible, but always in the same day the interview took place. Formal recordings were uploaded into a
secure, password protected cloud drive, and transferred to the Otter-ai software platform for transcription. Interviews were transcribed verbatim, including colloquial slang, which provides important context for the experiences of my research population. Please see Appendix D for a list of acronym and abbreviation definitions. Verbal consent for both the interview and the recording process was obtained from each participant before the interview and is present on the recording. Participant observation and clinical shadowing consent was waived by both the hospital and the IRB, and all data from this phase of collection was completely de-identified. All participants in this study, whether physician, clinical care team, community provider or patient were assigned pseudonyms were for an additional layer of anonymity. All interviews and observation field notes were assigned a coded participant ID for further identity protection.

**Ensuring Anonymity and Protecting Confidentiality of Participants**

As this is a sensitive research topic that could bring undue harm to participants, perfect anonymity was given to each interview participant, including “masking legal name, location, pseudonyms linked to name or location, appearance and behavior patterns, or social categorization” and quantitative data was de-identified and reported in aggregate (Coffelt 2017: 2). As the principal investigator for this study, I had an obligation to create specific protections for the varied participants that took part in this research. Additional steps were taken to ensure the anonymity and safety of participants. In all field notes and any conference presentations or publications, participants were given pseudonyms in order to protect their identity. Patients consented to treatment in the BRIDGE program, and also gave verbal consent to participate in the study and to be interviewed. Participants had the ability to withdraw
consent at any time, and verbal verification was obtained prior to each interview to assure that the participant understood the voluntary nature and anonymity afforded by their participation. Interviews were recorded only with consent, and any materials created were thoroughly de-identified if used for publication.

Pseudonyms were created of all locations referenced in this research “as a way to protect the confidentiality of patients and clinician informants” (Kaiser 2009). Topics discussed with patients were sensitive, could be considered stigmatizing, and potentially incriminating; for clinicians who hold very public positions, pseudonyms allowed them to discuss their thoughts and opinions in a more candid manner without fear of retaliatory measures. Additionally, throughout the dissertation, I change details that could reveal participant identities, though the original narrative remains relatively unchanged. There were no known risks associated with participating in this research and USF IRB approval and exemption was obtained for this study.

My research questions were discussed in Chapter 1. Below, in Table 3.1 I summarize each research question, along with the methods used to address the question, while Table 3.3 reflects a research timeline, highlighting the amount of time spent on each data collection method across research sites. Table 3.2 is a list of research sites, providing brief context of each of the 4 sites.
Table 3.1: Research Questions, Methods, and Analysis

<table>
<thead>
<tr>
<th>RESEARCH QUESTION</th>
<th>METHOD</th>
<th>ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are cultural divides that exist among patients, physicians, and community</td>
<td>Participant</td>
<td>Open-ended Interviews</td>
</tr>
<tr>
<td>treatment providers around addiction, and how does emergency care relate to and</td>
<td>Observation</td>
<td>Thematic Analysis</td>
</tr>
<tr>
<td>contribute to addiction trajectories?</td>
<td>Clinical Shadowing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EHR Data Collection</td>
<td>Semi-Structured Interviews</td>
</tr>
<tr>
<td></td>
<td>Participant</td>
<td>Unstructured Interviews</td>
</tr>
<tr>
<td>What are the outcomes of integrating a lived experience model of addiction</td>
<td>Observation</td>
<td>n/a</td>
</tr>
<tr>
<td>into clinical care, and does this integration allow patients and providers to</td>
<td>Clinical Shadowing</td>
<td>Qualitative Content</td>
</tr>
<tr>
<td>have an active role in acute addiction treatment and recovery during the ED</td>
<td>EHR Data Collection</td>
<td>Analysis</td>
</tr>
<tr>
<td>encounter and after discharge?</td>
<td>Open-ended Interviews</td>
<td></td>
</tr>
<tr>
<td>What impact does the implementation of formal clinical treatment pathways for</td>
<td>Program Evaluation</td>
<td>CDC-Based Program</td>
</tr>
<tr>
<td>addiction have on the issue of learned helplessness for both patients and</td>
<td>EHR Data Collection</td>
<td>Performance and Evaluation (PPEO)</td>
</tr>
<tr>
<td>providers?</td>
<td>Open-ended Interviews</td>
<td></td>
</tr>
<tr>
<td>What are the programmatic outcomes of integrating a formal treatment pathway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for addiction into acute clinical care?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interviews n=30
Hospital-Based Treatment Providers n= 8
Community-Based Treatment Providers n= 7
Bridge Patients n= 10
Community Stakeholders n= 5

Table 3.2: Field Sites and Type

<table>
<thead>
<tr>
<th>Main Field Sites</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ED</td>
<td>An emergency department located within a large teaching hospital, and the areas only level 5 trauma center. This hospital is the</td>
</tr>
<tr>
<td></td>
<td>communities main safety net hospital, providing care for most of the areas indigent population. The county that the hospital is</td>
</tr>
<tr>
<td></td>
<td>located in reported one of the highest overdose rates for the state of Florida in 2020, and the three zipcodes associated with the</td>
</tr>
<tr>
<td></td>
<td>highest overdose in the county ring the hospital.</td>
</tr>
<tr>
<td>Stony Vale Treatment Center</td>
<td>An SUD treatment center in the community that provides treatment for addiction and mental health issues. Treatments include</td>
</tr>
<tr>
<td></td>
<td>outpatient, intensive outpatient, inpatient residential, and a dedicated program for mothers.</td>
</tr>
<tr>
<td>Four Pines Recovery</td>
<td>An SUD treatment center in the community that provides treatment for addiction and mental health issues. Treatments include</td>
</tr>
<tr>
<td></td>
<td>outpatient, intensive outpatient, onsite detoxification, temporary housing, and offsite residential treatment.</td>
</tr>
</tbody>
</table>
Sampling and Recruiting

The study population for this research was separated into several key groups: Opioid Use Disorder (OUD) patients enrolled in the BRIDGE program, hospital-based treatment providers, community-based treatment providers, and community stakeholders. Each of these groups are discussed in detail below.

Table 3.3: Data Collection Methods

<table>
<thead>
<tr>
<th>Data Collection Method</th>
<th>Research Site 1- Hospital</th>
<th>Research Site 2- Stony Vale Treatment Center</th>
<th>Research Site 3- Four Pines Recovery</th>
<th>Community Research</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Observation</td>
<td>1,300 hours</td>
<td>60 hours</td>
<td>60 hours</td>
<td>50 hours</td>
<td>1,470 hours</td>
</tr>
<tr>
<td>Clinical Shadowing</td>
<td>80 hours</td>
<td>8 hours</td>
<td>8 hours</td>
<td>n/a</td>
<td>96 hours</td>
</tr>
<tr>
<td>Semi-Structured Interviews</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Unstructured Interviews</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>

Patients Experiencing Opioid Use Disorder

Bridge patients were identified through ED-based research associates and peer recovery specialists who had access to the ED patient care system, and patient track board (how patients are organized) and looked through charts for patients appropriate for BRIDGE enrollment on a 24-hour basis, seven days a week. Peer recovery specialists are individuals in recovery from a substance use disorder that have received additional training and certification to work in healthcare settings. Any patient with OUD that agreed to treatment was eligible for pathway enrollment. Quantitative data metrics (see table 1) were then pulled from the charts of patients enrolled in the BRIDGE program. Exclusion for OUD patients included anyone that declined to consent to pathway treatment. In order to participant in the interviewing process,

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6 Dependent on research associate availability.
7 Patients are not screened if they are critically ill, homicidal, suicidal, or in police custody.
BRIDGE patients had to be 18 years or older, be diagnosed with OUD\(^8\), and be enrolled in the BRIDGE pathway. Interviews with patients consisted of a mix of patients currently in the hospital, patients who were enrolled in the BRIDGE program and then transferred to residential treatment in the community, patients who achieved sustained remission through BRIDGE enrollment and community treatment, and patients that had multiple enrollments with unsuccessful referral to care.

*Hospital-Based Treatment Providers*

Hospital-based treatment providers were identified through participant observation and snowball sampling, and included emergency medicine physicians and residents, psychiatric physicians, and ancillary care teams. Particular emphasis was placed on physicians and care teams that had direct involvement in providing patient care through the BRIDGE program, including physicians that were present at the inception of the program and could speak to the program’s evolution from September 2020 to September 2021.

*Community-Based Treatment Providers*

Community-based addiction treatment providers, defined as treatment centers in a particular community who provide care for substance use and mental health issues, comprised the two main treatment centers BRIDGE patients were referred to for treatment once discharged from the hospital: Stony Vale Treatment Center\(^9\)\(^*\), and Four Pines Recovery*. Each treatment center offers a broad array of services, including in-patient residential treatment,

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8 See Appendix E, and F for opioid scoring model and diagnostic criteria
9 All field sites are pseudonyms.
outpatient treatment, intensive outpatient treatment, health services, adolescent services, detoxification, case management and medical oversight, substance counseling, and medication for opioid use disorder treatment. Providers interviewed at each of these sites included the medication for opioid use director, the nursing supervisor, the outpatient services and detox coordinator, the medical director, and a member of the executive team.

**Community Stakeholders**

Community stakeholders included members of the community with significant insights into the planning and implementation of the BRIDGE program, and/or appeared to be essential to the maintenance and implementation of the BRIDGE program. Stakeholders who were interviewed included a political advocate who championed our work with opioid use disorder, an executive from a behavioral health entity that manages the federal healthcare dollars for the region, a member of a county task force on behavioral health, a state-wide supervisor of peer recovery specialists, and an organizer for a recovery-oriented system of care (ROSC) model.

**Data Collection Stream 1: BRIDGE Patient Health Records and Treatment Outcomes**

Data were collected from the electronic health records (EHR) for 500 patients enrolled in the BRIDGE pathway at the Hospital. This EHR data was collected to manage the program operationally as well as for this study. For the dissertation, clinical metrics were included that had the potential to group BRIDGE patients in meaningful ways to inform qualitative analysis (see Table 3.4). By focusing on EHR data, this method of targeted sampling also aided in understanding how medical data is compiled and follows a person throughout their healthcare trajectory (Carlson et al. 1994).
Table 3.4: Electronic Health Data Collected from BRIDGE Patients

<table>
<thead>
<tr>
<th>Demographic Data</th>
<th>Bridge Enrollment Data</th>
<th>Clinical Data</th>
<th>Drug Use Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Name</td>
<td>Primary Care Physician</td>
<td>IVDU status</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Medical Record Number</td>
<td>HIV Status</td>
<td>Last Opioid Used</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Date of Birth</td>
<td>HCV Status</td>
<td>Polysubstance Status</td>
</tr>
<tr>
<td>Out of County Resident</td>
<td>Referral Date</td>
<td>Significant Co-morbidities</td>
<td>Previous MOUD engagement</td>
</tr>
<tr>
<td>Insurance Status</td>
<td>Referral Site/Type</td>
<td>Mental Health co-morbidities</td>
<td>Benzodiazepine use</td>
</tr>
<tr>
<td>Housing Status</td>
<td>Follow-up Status</td>
<td>Overdose status</td>
<td>Methamphetamine use</td>
</tr>
<tr>
<td>Legal Hold Status</td>
<td>Contact Information</td>
<td>Admission status</td>
<td>Fentanyl use</td>
</tr>
<tr>
<td>Mean time of arrival</td>
<td>Narcan Received</td>
<td>Admitting Reason</td>
<td>Crack/Cocaine use</td>
</tr>
<tr>
<td>Weekend enrollment</td>
<td>MOUD induction</td>
<td>Psychiatry Assessment</td>
<td>Other use not listed</td>
</tr>
</tbody>
</table>

Data collection began September 1, 2018, was concluded on October 1st, 2021.

Qualitative data collection methods included participant observation, clinical shadowing (see table 3.9), and ethnographic interviews. Support for clinical shadowing and participant observation data collection in the ED included becoming credentialed with the hospital, as well as direct support from the medical director and associate medical director of the ED. Analysis of programmatic outcomes were done utilizing the Centers for Disease Control (CDC) Program Performance and Evaluation (PPEO) criteria (for an example, see appendix A). Ethnographic interview data consisted of 30 interviews with BRIDGE patients, clinical care providers in the ED, substance use care providers, and community stakeholders.

Data Collection Stream 2: Ethnography

Ethnographic Interviewing

As stated above, ethnographic interviewing provides rich individual stories and experiences to a variety of trajectories, outcomes, and socio-demographic factors regarding opioid addiction, as well as a means of contextualizing quantitative healthcare data collected on BRIDGE patients. Thirty semi-structured interviews were conducted for this research and were
informed by James P. Spradley’s *The Ethnographic Interview* (Spradley 1979). While conversations occurred organically with either a small subset of probing questions (Table 3.5), there were particular foci, such as personal experiences from clinicians and patients regarding participation in the BRIDGE program, thoughts on how well the program was integrated into ED care, or how individual experiences interfaced with the program both in treating and being treated. There was also a specific interview question for physicians as to their thoughts on how the treatment pathway related to their practice of medicine. All interviews took place in person, and were conducted at various sites, including the hospital, treatment partner facilities, an off-site clinical facility, and a restaurant/café. All interviews were completed by October 1, 2021.

*Table 3.5: Comparison of Semi-Structured and Unstructured Interviews*

<table>
<thead>
<tr>
<th>Semi-Structured Interviews</th>
<th>Unstructured Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>To explore patients thoughts, feelings, and beliefs about opioid use, as well as how patients perceive the healthcare they are receiving.</td>
</tr>
<tr>
<td><strong>Interview Focus</strong></td>
<td>Patients enrolled in the hospital treatment bridge in multiple phases of recovery</td>
</tr>
<tr>
<td><strong>Reasoning</strong></td>
<td>Collect qualitative, open-ended data without pre-determined questions. Best fit for patients who needed space to follow their addiction trajectory in a non-linear fashion, where more complex issues can be probed.</td>
</tr>
<tr>
<td><strong>Interview Strategies</strong></td>
<td>Unstructured Interviews, with open-ended questions based on specific topics during the natural flow of conversation</td>
</tr>
<tr>
<td>Semi-Structured Interview guide with 4-5 pre-established questions</td>
<td></td>
</tr>
</tbody>
</table>

*Semi-Structured Interviews*

Semi-structured interviewing is a highly adaptable data collection method, due to having a data focus, but also creating space for the interviewee to recall and interpret experiences and emotions, as well as ample opportunity for interviewer probing (LeCompte and Schensul 1999). This interviewing technique seemed to work best for clinical staff, who often
needed to pause to answer a phone, return a page, or take an urgent patient consult. There
was a comfortable, natural aspect to the interviews afforded to me by the social capital built up
over five years of working at the hospital, which allowed us to pick back up right where we left
off after each interruption, and for that I am fortunate.

Further, due to the open-ended nature of this interviewing technique, themes were able
to emerge in an organic way, even regarding content that interviewees assumed they were
intimately familiar with. For example, one clinician interviewed took the time to explore
experiences regarding a relative with alcohol use disorder, and how that subconsciously shaped
their outlook on addiction, though at the beginning of the interview they stated that they did
not have lived experience. It was only through conversational probing utilizing my experience
with addiction that they were able to arrive at a previously unrecognized reality that one of the
reasons this clinician was striving to change the way treatment is offered for substance use
disorder was reaching forward from a long suppressed past.

Table 3.6: Sample Semi-Structured Interview Questions

<table>
<thead>
<tr>
<th>Provider Questions</th>
<th>Patient Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How has your clinical practice been since MOUD bridge program implementation?</td>
<td>How has the quality of your care been during your time in the hospital/treatment center?</td>
</tr>
<tr>
<td>How does this compare to clinical practice before the bridge program implementation? Has the program been easy to use?</td>
<td>How does this compare to previous treatment you’ve received (if any) for OUD before this bridge program was available?</td>
</tr>
<tr>
<td>Has a clear, dedicated treatment protocol made care of OUD patients easier? How has direct communication with (hospital/treatment center) in your opinion, affected the quality of care patients receive?</td>
<td>(If applicable) Do you feel receiving medication for OUD improved the quality of your care?</td>
</tr>
<tr>
<td>Are there any difficulties you have encountered?</td>
<td>What has been positive/negative about this visit for you?</td>
</tr>
<tr>
<td>Is there anything we could be doing differently?</td>
<td>Is there anything we could be doing differently?</td>
</tr>
</tbody>
</table>
Unstructured Interviews

Unstructured interviews are “based on a clear plan that you keep constantly in mind but are also characterized by a minimum of control over the people’s responses” (Bernard 2006:212). This style of interviewing worked best for patients and gave them space to open up and express themselves “in their own terms, and at their own pace” (Bernard 2006:213). Patient experiences in seeking care often flow in a non-linear fashion throughout the trajectory of their addiction, and frequently intersects with seeking emergency care. In this interview space I also benefited from social capital, which will be reflected on more in-depth in the positionality section. Each interview began with the phrase “So tell me how all this got started for you” which was a mellow way to ease the patient into thinking about how their substance use and subsequent addiction trajectory started in a non-confrontational and thoughtful way.

Key probe points emerged during the conversation that were similar across patients interviewed, e.g., parents who were absent or abusive, parents who did/sold drugs, an older sibling that did/sold drugs, drug use that began at school, early entry into the criminal justice system, food/housing insecurity, injury with opioids prescribed, etc. From these early experiences, we were able to recreate a timeline of where substance use and entry points into the healthcare system intersect from onset of use until where they were at currently in their treatment seeking during the time of interview. After building this timeline with unstructured discussion, the semi-structured questions (Table 3.8) were worked in to conversations at logical times regarding patient experiences with BRIDGE program treatment.
Interview Protocol and Analysis

All interviews were recorded with a digital recorder where possible and field notes from memory written directly after the interview when not able to be recorded. Verbal consent was gained before each interview, and consent was captured on the recording. Recordings were kept in a password locked cloud drive, and each interview was labeled anonymously with acronyms such as “PASV” (patient A; Stony Vale). Patients were each given a $20 Visa gift card to compensate them for their time after the interview concluded. Providers were offered compensation as well but declined so that more gift cards would be available for patients.

Qualitative Data Analysis

Figure 3.1 demonstrates a sample qualitative data analysis coding table from this study. During analysis, codes were assigned a particular trajectory, then each code grouping was used to code patient and provider interviews. Multiple codes were assigned as necessary. Each interview was also independently coded by two other anthropologist researchers to achieve intercoder reliability and data triangulation. All codes present in the analysis achieved agreement between myself and the two other anthropologist colleagues as being present in the interviews and relevant to the study. Of note, codes with a double asterisk next to their name were mentioned infrequently, though still provided significance in the analysis process.
Trajectory one focused on formal sources of knowledge acquisition on addiction that people gain throughout their varying life trajectories, and how that knowledge shapes their perceptions when it comes to seeking and providing care for OUD. Codes with an edu suffix were specifically focused on direct knowledge acquisition from professionals in addiction. For providers, I wanted to consider what sort of addiction training they received during their journey through medical school and residency, and training wildly varied among physicians interviewed. For example, some teaching hospitals affiliated with a particular medical school had a psychiatric receiving facility, which usually resulted in a small increase in access to addiction medicine education and access to OUD patients, while other hospitals/medical schools didn’t offer any sort of training at all. For patients, I wanted to ascertain where they received the most formal knowledge about OUD from, whether that be from physicians, drug court, addiction treatment counselors, or 12-step programs. For example, if a patient was told by an addiction counselor that the severe childhood trauma they endured did not contribute to

<table>
<thead>
<tr>
<th>Trajectory 1</th>
<th>Trajectory 2</th>
<th>Trajectory 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1_addictionedu</td>
<td>T2_drugseeking</td>
<td>T3_criminalrecord</td>
</tr>
<tr>
<td>T1_12stepedu</td>
<td>T2_fentanyl</td>
<td>T3_drughistory</td>
</tr>
<tr>
<td>T1_counselingedu</td>
<td>T2_insurance</td>
<td>T3_edvisits</td>
</tr>
<tr>
<td>T1_drugcourt</td>
<td>T2_pharmknowledge</td>
<td>T3_familydrughistory</td>
</tr>
<tr>
<td>T1_hcv</td>
<td>T2_MOUD</td>
<td>T3_financialissues</td>
</tr>
<tr>
<td>T1_injectiondruguse</td>
<td>T2_opioidprescribing</td>
<td>T3_fixedtrajectory</td>
</tr>
<tr>
<td>T1_medschooledu</td>
<td>T2_opioidwithdrawal</td>
<td>T3_foodinsecurity</td>
</tr>
<tr>
<td>T1_patientcommunication</td>
<td>T2_painmgmt</td>
<td>T3_hcv</td>
</tr>
<tr>
<td>T1_peercomfort</td>
<td>T2_polysubuse</td>
<td>T3_improvedexperiences</td>
</tr>
<tr>
<td>T1_providercommunication</td>
<td>T2_prescribercomfort</td>
<td>T3_lackofaccessstocare</td>
</tr>
<tr>
<td>T1_psychedu</td>
<td>T2_streetharm</td>
<td>T3_painmgmt</td>
</tr>
<tr>
<td>T1_residencyedu</td>
<td>T2_suppoding</td>
<td>T3_patientcommunication</td>
</tr>
<tr>
<td>T1_sdh</td>
<td>T2_unmanagedsx</td>
<td>T3_patiencylivedexp</td>
</tr>
<tr>
<td>T1_socialnarr</td>
<td></td>
<td>T3_peercomfort</td>
</tr>
<tr>
<td>T1_stigma</td>
<td></td>
<td>T3_providerlivedexp</td>
</tr>
<tr>
<td></td>
<td></td>
<td>T3_providerstigma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>T3_relate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>T3_stigma</td>
</tr>
</tbody>
</table>

Figure 3.1: Qualitative Data Analysis Coding Samples
their addiction, that they were just making excuses to keep getting high, that patient would have a greater sense of shame, confusion, and misplaced responsibility than a patient who learned from a physician that addiction is a chronic relapsing disease that can be successfully managed with a combination of medication and behavioral therapies.

Trajectory two dealt with the physical life and movement of the medication itself. I include MOUD and opioid medications for pain in this category, as they can be framed as a legitimate medication or an illicit drug depending on the situation. Numerous themes emerged from the analysis by following the trajectory of opioids, MOUD, and other related substances. For example, the number of patients who were placed on chronic pain management with opioid prescriptions after an accident, only to be removed from pain management once OUD was identified and told that “pain management doesn’t deal with addiction, you need to go to detox” even though physical dependency and subsequent OUD are inevitable in patients with long-term opioid use. So patients would move on to heroin or fentanyl once they were no longer able to access care. Or how patients self-medicate with buprenorphine on the street to manage withdrawal symptoms, much like people share antibiotics when ill. One physician remarked that if they knew this reality at the time of the ED encounter, they would be much more likely to give the patient a medication that had been tolerated well in the past.

Trajectory three was the most lengthy and dealt with the more visceral experiences people had around addiction in providing and seeking care. Focusing on the broadest category, patient and provider lived experiences, helped provide an overview of a particular person, and subsequent themes coded for lent a rich contextualization to the experiences. The most impactful theme that arose from this coding for me was a deep sense of ‘fixedness’ around
addiction (T3_fixedtrajectory). There was an interestingly static permanency assigned to OUD by patients and providers in varying ways, almost as if change just couldn’t be possible without herculean effort. This is learned helplessness; specifically, structurally trained helplessness, or intentionally trained diversion of the patient issue as “non-medical” or not a place of appropriate intervention for emergency medicine. Patients court ordered to 12-step programs were often permeated with a unique sense of resignation, affirming that they would “always be addicts” no matter what they did. That no matter how hard they tried, or how much they worked a program of recovery, the world would always see them as an addict; a fixed state of being. Providers, as well, displayed a sort of burned-out resignation towards OUD, that nothing they could do would “fix the problem” and nothing would ever change unless the patient really wanted to get “clean” (and if they did, the ED wasn’t the place to do it). Other themes included structural issues related to patients, a connection between a family history of drug use and OUD, and how much the MOUD BRIDGE improved experiences, both for patients and providers.

*Interview Limitations*

Interview limitations varied according to participant being interviewed. For treatment providers, limitations included frequent clinician interruptions during interviews due to needing to conduct many of the interviews “on shift,” frequent interruptions during MOUD staff interviews due to agencies being short-staffed during the pandemic, and clinician difficulty at remembering specific patient encounters. For BRIDGE patients, limitations included patient discomfort during the ED/hospital visit, interruptions for various treatment teams interacting with the patient, patients as a poor historian of their history, and a specific difficulty arranging
interviews with BRIDGE patients that were not currently engaged in some form of treatment at one of our treatment agency partners.

**Observations in this Study: Clinical Shadowing and Participant Observation**

For this research, two forms of observations were employed: clinical shadowing and participant observation. All participant observation and clinical shadowing data were recorded in field notes and analyzed regularly as a part of ongoing data collection (Morgan 2018). Regular thematic analysis of the field notes was key to guide and interpret further observations. Themes from field notes were also compared to the thematic analysis from formal interviews.

Table 3.7 highlights the differences between these two forms of observation.

<table>
<thead>
<tr>
<th></th>
<th>Participant Observation</th>
<th>Clinical Shadowing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To understand the profession as a whole</td>
<td>To understand how individuals in the profession practice</td>
</tr>
<tr>
<td>Object of observation</td>
<td>Group scan</td>
<td>Individual follow</td>
</tr>
<tr>
<td>Data recorded</td>
<td>Record group activities &amp; behaviors during event; take open and detailed notes</td>
<td>Record individual daily work activities &amp; behaviors; collect structured &amp; select data</td>
</tr>
<tr>
<td>Researcher</td>
<td>Present &amp; involved</td>
<td>Present but not involved</td>
</tr>
</tbody>
</table>

The focus of participant observation data collection was to re-create an as accurate (as possible) snapshot of how an emergency department (ED) functions during a shift, the different actors involved in patient care, and how patients flowed through the care structure during an ED visit. As I was also a credentialed employee of the hospital, every shift provided me ample opportunity for participant observation, with detailed field notes recorded after the shift was over. Further, by being an active participant of the ED space, and assisting in the development and execution of patient treatment and disposition planning through my status as an addiction.
professional for patients with opioid use disorder (OUD), I was able to see a level of hospital functioning that might not otherwise have been possible. I explore in more detail below the challenges that accompany my dual roles as researcher and employee, as well as health care orchestrator and anthropologist.

The focus of clinical shadowing with individual physicians during a clinical shift was to gain a deeper understanding of clinical decision making around patients with OUD, witness how physicians and patients interact in various exchanges during the ED encounter, and what perceptions physicians held overall on the realities of treating patients with OUD. This method differed from participant observation data collection with the fact that I did not actively participate in any clinical or operational care during shadowing shifts. I strictly shadowed a single physician through the course of their shift, in an attempt to ‘see through the eyes of the practitioner.’ Data was recorded throughout the shift, and included patient interactions, interactions with other clinical staff, decisions on patient care, and anything the physician disclosed to me or other colleagues regarding OUD patients assigned to them over the course of the shift.

**Participant Observation**

In health research, there is a “growing tendency among social scientists and researchers in medical professions to conduct participant observation research within [medical] institutions” (Oeye et al. 2007: 2296). One of the principal reasons for employing participant observation is that many aspects of “some social milieus are only visible to insiders, and only certain people can get inside” therefore, this method offered “a compelling blend of outsider
objectivity and insider knowledge, as a means of exemplifying both insider and outsider perspectives” (SAGE 2008: 79). Further, participant observation excelled in “capturing rules and norms that are taken for granted by experienced participants or cultural insiders and routine actions and social calculations that happen below the level of conscious thought” (SAGE 2008: 77-78). As such, participant observation was a logical choice for understanding the experiences of patients navigating the biomedical health system in tandem with experiences physicians may have regarding the many daily duties related to patient care that have become automated and subconscious. Participant observation is also the hallmark of ethnography, allowing the researcher to be “both insider by participating in the host community, and outsider by observing the social world of the host community” (Spradley 1980; Wind 2008: 80).

Clinical Shadowing

It was important to this research study to set aside official time to collect data on physician/patient interactions in relation to OUD. It was quite difficult at times to fade into the background to collect data, as I would often be pulled into patient issues, asked to assist with BRIDGE program navigation, treatment placement assistance, or some other such staff or research concern. Official clinical shadowing was a way for me to set aside protected time, and it was outlined at the beginning of a clinical shift that I was not there in an employee capacity, but as a researcher collecting data. This workflow was also an easily recognizable structure in medicine, whereas shadowing is an integrated part of clinical training for medical students, interns, and resident physicians. [These] methods allowed me to collect information from and about “real people doing real things” (Ortner 1984:142-144) “in resistance to existing
structures, in shaping (and being shaped by) those structures, and in working within those structures” (Eden 2013: 110).

**Reflexive Positionality**

An ongoing consideration of my positionality in relation to this research, throughout the entire process, was critically important to me. Much scientific research hinges on objectivity in data collection, however in anthropology it is not a...

“...matter of distance and non-involvement but of openness and honesty in accounting for all the factors that affect the process of anthropological production, including first and foremost the anthropologist him/herself and his/her role in producing his/her own product” (Kanaaneh 1997:4; Reeser 2014; 44).

My personal history with addiction bleeds through every move I make in this realm of research; I may not be in recovery personally, but my childhood and young adulthood was permeated with immediate family members, friends, acquaintances, and a community at large sedated by prescription opioid pills (among copious other substances), coupled with all the myriad baggage that comes along with that existence. I have witnessed multiple overdoses, given friends rides to donate blood plasma to buy pills, sat with friends through drug court proceedings that were never completed successfully. I have held hands in Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous meetings, opened bathroom doors to find loved ones with a needle in their arm, and sat up until the early morning hours to post someone’s bail. While these lived experiences are invaluable in my ability to both research and craft solutions
for persons who use drugs (PWUD), they also complicate how I am seen in and move through spaces.

Throughout my time at the hospital, you could see the result of this active complication in the way people were consistently attempting to make sense of my existence— at once I appeared clinical and non-clinical, medical, and non-medical, drug user and non-drug user simultaneously, so that I often felt akin to a shadowy shapeshifter one can’t quite see or understand. I could always tell when a patient wanted to ask me about why I stood out, what was different about me, but didn’t want to offend me. Eyes darting slightly back and forth, rocking on their hands. Finally— “There’s something not right about you, did you used to be an addict? You know too much.” I could tell when a clinician would look at me surreptitiously, multiple times over an encounter, and I would invariably have to explain how I ‘knew so much’ about OUD. “Ah” they would say, “now it makes sense.”

This constant state of explaining myself also lent me a credibility that I otherwise would not have had; patients often eased into an open, familiar conversation with me— ‘she’s one of us.’ Physicians often eased into an open, familiar conversation with me as well. ‘She has lived experience, but she’s one of us.’ This did not always happen, to be sure, and greatly depended on the physician and context, and changed over time. However, I think this perceived sense of sameness allowed me the mobility to move fluidly between patient, physician, and community to build the BRIDGE program, but was something that I grappled with fairly often. One small twist in my life, one foot snagged on an errant root in the road, and I would not have been the researcher, but the researched. Not the person sent to help a patient with OUD, but the patient in need of help. This reality kept me grounded throughout the research process and motivated
me to continue to press forward in crafting solutions for my community regarding OUD, utilizing my unique state of being. Ethical considerations regarding this research and my emotional wellbeing are explored below.

**Ethical Considerations, and the Unique Challenges of Working in Clinical Spaces**

Research in populations with active and ongoing drug addictions bring unique ethical considerations and challenges (Anderson and McNair 2018). There are no explicitly stated ethical regulations or guidelines on how to conduct research in persons with opioid use disorder (OUD) outside of standard human subject’s research protections implemented as part of the Belmont report and adopted as standard of care in healthcare research through Good Clinical Practice (GCP) guidelines and credentialing regulations. Given my previous experiences and familiarity with both the research space and patient population, the following measures were taken to protect my participants. Detailed, anonymous field notes were recorded regarding both patient and physicians interacting with the BRIDGE program, along with subjective reflections over how each unique situation encountered during the course of a clinical shift affected patient care. According to James Spradley’s work on participant observation, this was a “limited-entry” social situation that required the permission of one (or more) person(s). Spradley states that “limited-entry social situations can become an excellent place to do your field study, provided the permission-gaining process goes smoothly” (Spradley 1980). I secured permission to observe from the director of clinical research, and hospital staff were receptive and comfortable with my presence as a result of working closely with them for the last five years.
Regarding either current or former drug using patients, information given by this population (e.g., identifying people, places, and things involving the use of illegal drugs) can result in serious social and legal ramifications to the participants, therefore I further altered fieldnotes that included any identifying information by changing things such as geographical locations, frequent meeting places, popular use locations, and so on, as well as asking that other people who were not directly participating in the study be referred to solely by nicknames. These extra safeguards helped to avoid any complications with completely identifiable factors, which may have resulted in either personal or legal repercussions. Additionally, as my research potentially involved situations where I might observe the occurrence of illegal activities, any information written about the observation of these activities included special care in the de-identification process to protect participants. I adhered to the conditions of my addiction training\textsuperscript{10} when in this situation and briefed all participants that if I witness elder abuse, child abuse, or homicidal/suicidal indications I will be mandated to report. Ultimately, however, I did not encounter this situation during data collection, nor any illegal activities that would have had significance to this study.

In regard to physicians, other clinical staff, and community stakeholders, interview data was considered both on an individual participant level, and in relation to the institutions in which informants work (medicine, emergency rooms, drug treatment centers, etc.). Common solutions to providing additional layers of anonymity included altering quoted data,

\textsuperscript{10} During graduate school, I attended a separate college for two years to earn an additional degree, which included biomedical, behavioral, and counseling training components related to addiction and co-occurring mental health disorders. This degree allowed me to become a certified addiction professional (CAP). This additional training also helped me to integrate further into the clinical environment.
organizations, locations, and timeframes. However, losing the insights of respondents due to data alteration can be particularly consequential for researchers seeking to impact clinical practice as these experiences can hold key insights for improving clinic care (Karnieli-Miller et al., 2009). Further, the community that I am conducting research in, specifically within the context of drug use and treatment is insular, and key stakeholders are easily recognizable regardless of efforts to alter data in the research dissemination. To address this difficulty, an alternate approach considered:

1) **Better informing respondents of the use of data (i.e., who is the audience for the study results and how will the study results be disseminated), and**

2) **Instituting practical steps to facilitate dialogue with respondents about how their data can be used (i.e., revising the informed consent process)**” (Kaiser 2010).

A key consideration in whether a particular plan of anonymity works well or poorly may lie in how the researcher is going to present data in the final product, what quotes will be used from interviews, etc. One method for alleviating this uncertainty was in the use of a post data collection consent form, which reflected actual data collected in addition to verbal consent to be interviewed (See Appendix G. The significance of such a document is that it is considers confidentiality in light of the actual data that has been collected and gives respondents the option to choose what level of identification they are comfortable with, in addition to allowing respondents to pinpoint which pieces of data they feel must be handled most carefully.

Additionally, interview probes were tailored to specific providers; personalizing interview questions not only showed a particular interest in the insights of the specific individual but
avoided easily replicable answers to the same questions across interviewees, which lends an additional level of broad anonymity in the final product. Total anonymity was given throughout all data collection, and coded identifications were used in lieu of names on any interview materials. Transcripts and field notes from interviews assigned these unique codes assisted with anonymity in data analysis, as I was familiar with who I interviewed, and verbally consented each participant, but in data cleaning and dissemination, I was not necessarily able to reconcile each interview with the individual participant.

**Emotional Wellbeing**

Often when thinking about researching in a clinical space, the planning for challenges is largely logistical, like barriers to access, or mobility in the space. One of the unique challenges also of critical importance is the human cost of working in emotionally grueling spaces. A lack of emphasis on researcher vulnerability is not uncommon; Kumar and Cavallaro (2014) assert that the design of “sensitive research focuses on ethical requirements and strategies for protecting participants while less attention has been given to the need for researcher protection” (648). Moneur (2013) considers “…the impact which sensitive research can have on researchers’ emotional wellbeing” citing that social scientists in particular “are adept at mitigating risk to participants, [but] discussing and developing the same degree of consideration for [themselves] is lacking” (1888). Micanovic and colleagues (2020) focus on ethnographic research in particular, which is “characterized by immersion, reflexivity, and rapport [which] can be unpredictable and uncontrollable, producing a wide range of emotional responses” (1).
It is also important to recognize when there is a greater than normal emotional risk to researchers in sensitive spaces due to individual life experiences (Lee-Treweek and Linkogle 2000). Hubbard et al. (2001) outlines the importance of including the emotional wellbeing of researchers in study design, resolving that “unless emotion in research is acknowledged, not only will researchers be left vulnerable, but also our understandings of the social world will remain impoverished” as the emotional reflexivity of the researcher is vital to the research process (137). In consideration of my personal lived experiences in relation to this research and research population, additional safeguards were implemented into this research study to gauge my emotional wellbeing, including frequent check ins with mentors and advisors, meticulous subjective field notes in order to ascertain current emotional state, and adequate time in between in-depth interviews to allow time to emotionally reset.

Each of the methods of data collection and analysis serves to capture a contrasting element of patient and provider experiences in providing care of OUD in study sites and spaces. In chapters to follow, I consider findings from each method individually as well as integrated into a complementary whole to better understand OUD experiences, treatments, and future care pathways.
Chapter 4

Life in the Emergency Department before the BRIDGE Pathway

As discussed in the previous chapter, this research focuses on addiction trajectories and addiction treatment in acute spaces. The notion of addiction trajectories has been teased out by medical anthropologists Raikhel and Garriott by considering ‘clinically engaged social science literature that examines illness trajectories’ (2013: 8). An illness trajectory framework is used to consider “the physiological unfolding of a patients’ disease” and “the total organization of work done over that course, plus the impact on those involved with that work and its organization.” (Strauss et al 1985:31). Strauss et al. argue that a trajectory concept is necessary to understand how an illness is managed socially as well as clinically. This understanding is vital to providing care for structurally vulnerable patients without a clear path for treatment in the emergency space. Using a ‘trajectory’ framework as the basis for this research allowed me to ‘move away from a static focus on symptoms, disease markers, or medical compliance toward a deeper understanding organized along a non-linear continuum regarding how and why individuals ‘undergo changes and the relationship between individual experiences, life-course events, and environmental processes’ (Raikhel and Garriott 2013:9).

In addiction literature, clinical education around addiction, addiction medicine (to a degree), psychology, all the way to 12-step programs usually consider the process of addiction to be a ‘unilinear, uniform trajectory from use to treatment’ to recovery (Lovell 2013). During
the course of my research, I have found active use, treatment, and recovery to be anything but linear or uniform. It is often winding, disordered, messy, confusing, and unsupported. Frequently, key insights into the process of use and recovery are not in the treatment, but in the movement between treatment spaces (Raikhel and Garriott 2013; Garcia 2013).

Ethnography is an effective way to contextualize how trajectories originate, converge, and digress, along with how this plays out in both the giving and receiving of care for OUD. This chapter, as well as chapter five, emphasizes the ethnographic narratives of addiction trajectories, organized by pre-intervention (chapter four) and post-intervention (chapter five).

As a reminder, all names used in the following chapters are pseudonyms, and other minor details may also change to further protect participant identities. Interview data has been edited for clarity.

Figures 4.1, 4.2, and 4.3 demonstrate the coding frequency of key themes from this dissertation. Each figure represents a trajectory, and each trajectory is organized by community stakeholders, providers, and patients. Themes with a greater than 20% frequency were analyzed across groups and trajectories, and Table 4.1 reflects key themes organized into before and after BRIDGE implementation. These themes are explored ethnographically in this chapter, and chapter five. Patient health records and other quantitative metrics and outcomes will be discussed in chapter six, followed by a chapter that synthesizes and integrates of all the themes of this study, as well as future considerations.
Figure 4.1 Trajectory One Key Theme Frequency
Figure 4.2 Trajectory Two Key Theme Frequency
Figure 4.3 Trajectory Three Key Theme Frequency
Table 4.1: Key Themes Pre and Post BRIDGE Implementation

<table>
<thead>
<tr>
<th>Pre-Implementation Key Themes</th>
<th>Frequency of Key Themes - Physicians</th>
<th>Frequency of Key Themes - Patients</th>
<th>Post-Implementation Key Themes</th>
<th>Frequency of Key Themes - Physicians</th>
<th>Frequency of Key Themes - Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of formal medical training in medical school on addiction</td>
<td>86% (n=15 provider interviews)</td>
<td>N/A</td>
<td>Increased Treatment Comfort</td>
<td>100% (n=15 provider interviews)</td>
<td>100% (n=10 patient interviews)</td>
</tr>
<tr>
<td>Shared sense of helplessness</td>
<td>75% (n=20 provider/stakeholder interviews)</td>
<td>100% (n=10 patient interviews)</td>
<td>Feelings of Empowerment</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>80% (n=10 patient interview)</td>
</tr>
<tr>
<td>Poor patient care</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>100% (n=10 patient interviews)</td>
<td>Meaningful/Improved Patient Care</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>100% (n=10 patient interviews)</td>
</tr>
<tr>
<td>Miscommunication</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>100% (n=10 patient interviews)</td>
<td>Improved Communication</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>100% (n=10 patient interviews)</td>
</tr>
<tr>
<td>&quot;It's not my job to get them high&quot;</td>
<td>23% (n=15 provider interviews)</td>
<td>60% (n=10 patient interviews)</td>
<td>Stigma Reduction</td>
<td>100% (n=15 provider interviews)</td>
<td>80% (n=10 patient interviews)</td>
</tr>
<tr>
<td>Burnout</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>N/A</td>
<td>Avoiding Burnout</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>N/A</td>
</tr>
<tr>
<td>Treatment frustration</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>100% (n=10 patient interviews)</td>
<td>Recognizing Structure</td>
<td>75% (n=20 provider/stakeholder interviews)</td>
<td>80% (n=10 patient interviews)</td>
</tr>
<tr>
<td>The &quot;Drug Seeking&quot; Patient</td>
<td>87.5% (n=15 provider interviews)</td>
<td>100% (n=10 patient interviews)</td>
<td>Improved Patient Care</td>
<td>100% (n=15 provider interviews)</td>
<td>100% (n=10 patient interviews)</td>
</tr>
<tr>
<td>&quot;MOUD is short-term&quot;</td>
<td>25% (n=15 provider interviews)</td>
<td>77.5% (n=10 patient interviews)</td>
<td>Changing Attitudes</td>
<td>100% (n=15 provider interviews)</td>
<td>100% (n=10 patient interviews)</td>
</tr>
<tr>
<td>Zero Sum &quot;Choice v No Choice&quot;*</td>
<td>80%*</td>
<td>75*</td>
<td>Increased Understanding of Addiction</td>
<td>100% (n=15 provider interviews)</td>
<td>100% (n=10 patient interviews)</td>
</tr>
<tr>
<td>Hospital as Safety Net; Lack of Structural Significance</td>
<td>37.5% (n=20 provider/stakeholder interviews)</td>
<td>80% (n=10 patient interviews)</td>
<td>Importance of Structure</td>
<td>100% (n=20 provider/stakeholder interviews)</td>
<td>100% (n=10 patient interviews)</td>
</tr>
<tr>
<td>Patient/Provider Mistrust</td>
<td>80%*</td>
<td>95%*</td>
<td>Closing the Empathy Gap</td>
<td>94% (n=15 provider interviews)</td>
<td>60% (n=10 patient interviews)</td>
</tr>
</tbody>
</table>

*Key theme is an average based on 1500 hours of participant observation
Early Days in the ED: Pre-Implementation of BRIDGE

Addiction cannot be reduced to a biological condition—it must be seen as a “trajectory of experience that traverses the biological and the social, the medical and the legal, the cultural and the political” (Raikhel and Garriott 2013).

The trajectories approach taken here is different from typical ethnographies in its focus both on the social interactions that are happening in the process of care in different spaces with different providers in and out of the hospital setting, and its goal of creating an applied intervention as an outcome of the ethnography. A trajectory framework also extends the concept of lived experience to examine not just the drug user as homogenous, or the physician as hyper-focused on biomedical intervention, but moves us to a new space where knowledge, perceptions, subjective experiences, and available therapies informs new trajectories of care. This study builds on my previous research (Henderson 2018) and extends it to develop a “best practice” clinical treatment pathway that complies with state laws that are specific to the prescribing and dispensing of MOUD treatment in an acute setting for patients with OUD. In clinical care, best practice can be defined as "the 'best way' to identify, collect, evaluate, disseminate, and implement information about as well as to monitor the outcomes of health care interventions for patients/population groups and defined indications or conditions" (Perleth et al. 2001). The following sections begin with an overview of the gaps in medical education for emergency medicine providers on addiction, then moves into ethnographic data on education and experiences by both providers and patients focused on what it was like to seek and provide care for OUD before the BRIDGE pathway was available.
Medical Education and Drug Addiction

Before any new endeavor, there first comes some sort of preliminary survey of what you know and don’t know before commencement. With this in mind, the first step of building the BRIDGE pathway based on findings from my MA thesis was to assess and better understand the knowledge and perceptions of ED providers on addiction (specifically OUD), available treatments for OUD, and what role they saw the ED playing in providing those treatments. I had a feeling at the start that the odds of discovering a wealth of knowledge and positive perceptions were very low. Spoilers, I was right, but with good reason. There is an extreme lack of educational curricula for physicians on treating addiction during medical training. To emphasize this, a seminal American Medical Association (AMA) paper from almost a decade ago highlights the critical need for addiction medicine training (Wood et al 2013). More recent articles (within the last three years) still cite the same glaring gap in training that is affecting millions of patients and thousands of EDs a year (Hoffman 2018; Arya et al 2019; Scutti 2019; Morreale et al 2020; Wedge 2020; Lai 2020).

Particularly eye opening is a study (Klimas 2021), completed by the National Institutes on Drug Abuse, which found six key issues: (1) A need for structured addictions training, (2) Insufficient time spent on addiction education, (3) Insufficient clinical training and clinical skill development, (4) Lack of patient-centeredness and empathy in training environment, (5) Insufficient implementation of evidence-based medicine, and (6) Prevailing stigmas towards addiction medicine. What I observed during the course of this study echoes Klimas findings, which I will discuss in detail in the following sections.
In speaking with physicians at my field site about what sort of medical training they received around addiction, their experiences closely mirrored the gaps these articles demonstrate in medical education. Q, a senior physician, recalls the depth of their medical school training on addiction encompassing an assignment to go to a 12-step meeting:

**Heather:** If we go back to your medical training, what sort of training did you, if any, receive for addiction?

**Q:** Very little. Very little. I think I maybe remember a little bit of sort of lip service towards it, but not any kind of in depth experience. I did have some required psychiatry rotations in medical school. I don't remember dealing with any substance issues directly during that, we did have an assignment to go to an Alcoholics Anonymous meeting during that [rotation]. And that was a very interesting experience, an interesting afternoon with an AA group. I wasn't sure how to interact, I was a little nervous to go in there. Because you know, you go, you feel what's...

**Heather:** Well it's problematic, because they're supposed to be an anonymized group.

**Q:** Right. Then you go as a field trip, and you know, they all have something in common, and they all have a shared experience and a shared sort of reason for being there. And then you're there. Like, you don't want to feel like you're, you know, putting them in the fishbowl and just, you know, ogling at them. But that actually turned out to be a really, really good experience. I just, I kind of sat in the back, didn't really say much for most of the meeting. But eventually, they came to me and wanted me to say something. And I was very forthright and told them who I was, and why I was there. And thanked them for letting me be there. They were all actually very, very cool about it.

It seems to be sound reasoning to send medical students to Alcoholics Anonymous meetings as a good way to illustrate to students that people who struggle with substances are “just like them.” This practice is still advocated for in medical schools (Baldwin 2017), however, the reality of this assignment falls far short of its intended goals. One drop-in 12-step meeting does not do nearly enough to provide the context and structural education a medical student would need to comfortably interact with a patient in an acute setting, especially with no previous
exposure to addiction. A new attending physician, K, reflects on the few days of specialized training they received on substance use, out of four years of medical school:

**Heather:** When you first started your medical training, what, if any, guidance, or training did you receive around substance use disorders and comorbid, serious mental health issues that go with substance use disorders?

**K:** Um, I don’t remember any specifics. I know for a fact, during our psychiatry modules, we talked about substance use, and actually one of our psychiatric professors was a substance use disorder specialist. So we actually had, you know, a few days of specialized training, but it [the training] kind of covered, you know, everything from alcohol to any number of legal and illegal substances used. But I’d say probably... and they also integrated some of that through our *on-doctoring*, or hands on portion. So it was a longitudinal thing with, you know, chunks of specialized time. But overall, I would say probably a total of two or three weeks specifically of mental health, and substance use disorders that went along with that. Now, mental health was a big part of the entire integration of our medical school, but specifically towards substance use? Two to three weeks, I would say.

**Heather:** Do you feel like that prepared you?

**K:** No. Not at all. Not at all. I mean, as much as you could be prepared to go and actually see somebody with substance use issues. I was very fortunate where I trained, we had an inpatient psychiatry system. So I actually had a couple days where we went in with our inpatient rehab, we actually had an inpatient substance use program [there]. And I went in with them [the patients] and like, did some of their meetings, things like that.

But I just feel like, in general and medicine, talking about some, you know, mental health and psychiatric or substance use disorders, I don’t know if you can be prepared to actually go into it, to get hands on from a didactic lecture to an actual, in real life [patient] encounter.

Here again the lack of preparedness that newly practicing physicians have in feeling equipped to handle an OUD patient is illustrated—a situation that the majority of physicians who participated in the study had experienced. Of physicians interviewed, 86% reported either a severe lack of, or total absence of addiction medicine training in both medical school and residency. This lack of preparedness inevitably leads to poor patient interactions, which in turn will eventually lead to burnout in the physician in caring for this patient population. Resident
Physician in training, (who I refer to as R) reflects on their training, and an impactful memory which draws a parallel between substance use disorders and other commonly stigmatized disease states frequently treated in the ED:

**Heather**: When you were training in medical school, did you receive any training at all on addiction or substance use disorders? Or substance use disorders in the presence of other mental health issues? What did that look like for you?

**R**: Um, yes, and no. I mean, naturally, I think I got the [addiction] lectures peppered in, in my first and second year, [but] it’s largely didactics. And if I had to guess, I’d say there were probably some very forgettable PowerPoint lectures in the first two years. As far as formal training, specific to my future career as an ER doctor, I don’t think so. There were some conversations that were memorable from people specifically. I had some good conversations about sickle cell patients. [their hospital] had a pretty large sickle cell population, just because of the kind of population demographics they have down there.

And so I did get some good training about sensitivities to what the disease process looks like, and concomitant opioid addiction, as far as iatrogenic. So I had some good conversations with attendings about being sensitive to that, specifically with language, of not referring to people as ‘Sicklers’¹¹, and things like that. But on, like, opiate [care] pathways or [treatment] opportunities, it was just a few conversations about the Narcan I was starting to utilize [for overdoses] but not really any implementation. So yeah, I got pretty little [addiction education] in medical school.

Physicians train by evaluating case studies that illustrate patient encounters involving “cultural” variables that could impact care, such as ‘African American woman with sickle cell anemia and opioid dependence who is medication non-compliant and missed her last visit’, or ‘Mexican immigrant not adhering to a diabetic diet’ (Metzl and Hanson 2014: 126). But what is often glossed as “culture” is not isolated to the individual; is also intersectional:

“...most people belong to multiple groups at once, and those groups are shaped by varying social, economic, political, and environmental contexts. As a result, different

¹¹ A sickler is a person living with sickle cell anemia. This is an example of stigmatizing language, with inherent discrimination against the patient with sickle cell anemia, which can often lead to additional mental and psychological pain in addition to the severe physiological pain of this disease. OUD is often a common co-occurring disease.
aspects of identity – including race, class, religion, gender identity, sexual orientation, nationality, and language – may intersect in different ways for different people in different contexts” (Crenshaw 1991: 1245).

The clinical significance of groups can extend even further to include marginalized subcultural groups as well (e.g., intravenous drug use and addiction, HIV, sickle cell, etc.) with whole new intersections and implications. This lack of training, however, coupled with the lack of structural support for the physician (e.g., treatment pathways, linkage to care, etc.) in the ED seemed to lead to a sort of learned helplessness on behalf of the clinical care team. Drawing from my many thousands of hours of participant observation in my study site, this often translated to a general air of defeat around OUD patients that usually began at first glance of the chart and continued on through patient discharge. What underlies such a phenomenon? What could be done to change this?

A Shared Sense of Helplessness in Clinical Care

As discussed in chapter two, learned helplessness (LH) is a way to describe what happens when a person becomes conditioned by their environment and circumstances to believe they are powerless over their current conditions; that whatever they are facing is unchangeable or inescapable. LH is something that I learned about early on in my addiction training, and the concept is framed within an actionable tool referred to as motivational interviewing (MI). MI is a tool that is employed by social workers, psychologists, psychiatrists, and/or other mental health professionals in an attempt to uncover the root of why a person feels they are powerlessness and/or have a persistent inability to succeed. This often results in
the person feeling that because whatever the issue is seems to be beyond their control, they do not take steps to resolve it, even though they have the power to do so.

The concept of LH was only framed as a process specific to patients, yet while working at the hospital I had numerous encounters where I observed LH at multiple levels of clinical care. I am not sure if it is because I was going through clinical addiction training at the time, and LH and MI were very fresh in my mind, but during the initial phase of BRIDGE implementation, it seemed pretty clear to me that this may have been what was occurring. The following examples demonstrate what I saw in those early days; later in the chapter I discuss how the BRIDGE pathway has appeared to help mitigate this phenomenon. The following section contains short vignettes form my work in the ED, where I specifically observed learned helplessness that may not have occurred with a different disease state with a formally built out treatment process. The vignettes are varied and include different care teams to demonstrate how this issue permeates multiple steps of care for OUD patients.

**A Frantic Consult**

My list this day included making additional information packets to help social workers discuss difficult topics with patients like a new HIV diagnosis, or a positive hepatitis C result due to injection drug use. I waited weeks for some of the materials to come in from various manufacturers, and today was finally the day. As I crossed the hall and badged into the ED, arms burgeoning with brown manila envelopes stuffed to the brim, I saw a member of my team rushing down the hallway with a social worker. “We were just about to come get you!” the social worker said breathlessly. “R [a physician] is about to discharge a patient and I can’t stop
them, I don’t know what to do, you have to help.” They quickly turned around to go back to where the patient was, expecting that I would follow. I looked quizzically at my team member, not sure what I could do, then fell into step beside them to figure out what was going on. The patient had come to the ED with his wife for a ‘subjective neurological deficit’ which translates to the patient thinks there is something wrong with them so we have to run tests to see. The neurological work-up was negative for anything acute, though the patient argued that they knew their symptoms were related to the Suboxone their primary care physician had prescribed them for OUD. The patient was extremely distressed, had excellent private insurance, and wanted to see someone that day.

I turned to R and asked if there was anything we could do to try to get him in somewhere, even if it was an appointment within the next few days. “There’s nothing I can do” R said, turning to the social worker. “That patient has about 30 minutes until I discharge him. If you want to go in there, and you know, put a bug in his ear that he’s suicidal, then I can Baker Act him, and he’ll wind up in a facility today. Otherwise, discharge orders are going in.” In this moment, R felt the only tools available to them regarding this patients’ care was either a mental health legal hold, or discharge, and their requirement to rule out acute conditions had been satisfied. The social worker, because they could not manage a same-day appointment for the patient, felt defeated as well. Ultimately, the patient was discharged forty minutes after my exchange with R, sans Baker Act. Here, we see all three trajectories converge on this patient.

12 The Baker Act is a Florida law that enables families and loved ones to provide emergency mental health services and temporary detention for people who are impaired because of their mental illness, and who are unable to determine their needs for treatment (UFH 2021).
encounter—a lack of knowledge around addiction management, a lack of treatment options, and a lack of prior experience in successfully navigating a scenario such as this.

A Day at Disney World

It was around 10am, and I was standing in the kitchen over a pot of rice, a component of my lunch that day for the hospital. My pager started rattling around on my desk, but I figured it could wait until I could finish my food. Another loud rattle, followed by another. Then another. It was quite odd to be paged five times back to back, so I ambled over to my desk to see what could be so urgent. I called the number back, and an unfamiliar social worker was on the other end of the line, and they were irate. “Your team was supposed to come talk to my patient yesterday, and all they did was bring a flyer. This is unacceptable; it’s poor patient care. Now I need to discharge them and they won’t leave.” What patient were they referencing, I asked? “It’s Isaac Simmons, they have a million questions that I can’t answer. I’m not the expert in this, you are.” I calmly told them that whatever barriers to discharging the patient they were experiencing could be the result of anxiety, needed clarification over treatment plans, or perhaps a latent hesitancy to leave a safe hospital space for the unknown. “It’s still poor patient care. It’s unacceptable.” After spending several more minutes talking through common concerns someone with OUD may have, we got a bit closer to the root cause. “Well, regardless, the hospital is full; he is unfunded and needs to leave.” I let them know that I am driving in and will be leaving my house in the next five minutes; as soon as I get there, I will make seeing the patient my number one priority.
After arriving at the hospital, I pulled up Isaac’s chart as soon as I sat down to see what room they were in, then made my way to that floor. I rubbed hand sanitizer in as I stood in the hallway outside their room and heard a muffled “yeah” after softly knocking on the doorframe. Perched on the edge of the bed was an anxious looking man in his early thirties, with close cropped hair and a gold necklace, already dressed in street clothes. “Hi, I’m Heather with the MOUD team, I heard you have some questions about your discharge, can I come in and chat with you?” Isaac nodded as he stood up and started pacing. I could sense he wanted someone to talk to, so I sat quietly and waited for him to gather himself. “I don’t live here” he started. “A non-profit flew me and my fiancé out here to go to Disney World. She has terminal cancer; this will probably be her last trip.”

I nodded empathetically and signaled for him to continue as he teared up. “We were at the theme park when she started to get sick to her stomach. We got back to the rental car, and I realized that someone had broken into the car, took all of my electronics, my laptop, our cash. My chest started to hurt, and I guess I fell out. That’s how I ended up here.” When looking for his room number, I saw that his reason for admission was complications of endocarditis, a heart infection common to injection drug users. I nodded. “They said I got an infection from shooting up. I haven’t shot up in five years! I go to a clinic in California, I’m steady on Methadone, 135mg a day.” I asked him where he would continue care here, as he would need around six weeks of antibiotic infusions to resolve his infection, but he didn’t know. After a while, he relaxed a bit, and easily answered my questions regarding the California clinic, along with what means he had to pay for treatment. I informed him that I could arrange for him to guest dose at a facility here until his infusions were over.
Every solution that I proposed, however, was met with a mild undercurrent of uneasy opposition, ending in him asking why he couldn’t just stay at the hospital. I suspect he was afraid of relapsing; his old stomping grounds were around the corner one city over, where his mother lives. With a bit of patience I eventually managed to address all of Isaac’s concerns—we found a treatment center close to his mom’s house he could go to daily to receive guest doses of Methadone, we had a free-standing ED near there as well that could oversee his infusions, and both places were on a major bus line, as he needed to return the rental car. I felt buoyant as I walked back to the social work office to relay the solutions we found to the patients concerns.

I had to communicate the discharge plan to the social worker through a cracked office door, and they never looked up from their computer. “None of that [discharge plan] will be possible. He just needs to leave.” The floor nurse supervisor happened to be standing behind me charting during this one-sided conversation, and we shared a bit of a shocked glance. Ultimately, Isaac’s nurse and I managed to arrange the guest dosing at the facility, while the nurse supervisor sat down at a computer to oversee the infusion scheduling and print out bus routes from his mother’s house to the two facilities. On this day, what should have been a routine placement for social work devolved into turmoil, confusion, and anxiety with the addition of OUD complications. Here, we see the three trajectories, formal knowledge, pharmaceutical treatment, and visceral experiences converging in different ways. First, the social worker feigned a lack of knowledge or information on how to place patients at facilities, when this is often a core function of social work, and patients had been placed at this particular facility long before the BRIDGE pathway. Second, the seeming lack of treatment options for the
patient to co-locate care for the antibiotic’s infusions and MOUD further complicated matters. Third, I feel some sort of negative lived experience around substance use may have been at play on behalf of the social worker, owing to their outsized negative reactions.

A Traumatic Overdose

I received a page fairly late one evening and fumbled for my phone to return the call. The psychiatrist on the other end of the line told me that they received a consult for an OUD patient, and could I come enroll them into the MOUD BRIDGE? I let the psychiatrist know that I would be coming in the next morning, and they assured me that would be fine, the patient would not be discharged for another twenty-four hours. I thanked them and let them know that I would see the patient in the morning. I got to work early the next day, as I knew the patient would likely be sick from withdrawal and wanted to expedite their care. I walked by what I thought was their room but saw someone from environmental services wiping down the bed, sanitizer trails glistening in the sun shafts. I went back to the floor track board, assuming I had just misread the room number. No, I had the room number right. I backtracked to the room and asked the woman what happened to the patient in this room. “Oh, they left AMA” she said. Against medical advice (AMA) is a term used in clinical care to indicate the patient is leaving against the advice of the physician, and functions as a safeguard for the hospital and the physician against malpractice in case something happens to the patient once they leave care.

I tracked down the patient’s nurse and found out that I had literally just missed the patient; the internal medicine physician discharged the patient because they were threatening to leave AMA (presumably because they were sick). Upon talking with the nurse further, I
discovered that the patient came in as a traumatic overdose and had spent three days
intubated in the intensive care unit. This means they were well into the height of withdrawal
when they were extubated and moved to a lower acuity floor. I asked if any stabilizing
medications had been given for the patient’s symptoms, and she nodded her head no. “He
didn’t want to go to rehab so we discharged him.” I let her know that per psychiatry the MOUD
team was going to be by in the a.m. to enroll him in treatment. “I don’t know anything about
that, I didn’t know we had that.” Was he offered any harm reduction education, or a
prescription for naloxone before he left, I asked? “I have no idea. I don’t know anything about
that” she said. I knew if I’d just missed him he might still be in the discharge lounge, so I rushed
to find a phone. The discharge coordinator said he left the lounge ten minutes ago to catch a
bus. Where a phone number should be in his chart, there was 000-000-0000. The only number I
could find was for his mother, so I called it, though I was limited in what I could discuss without
the patient’s permission.

It turns out she knew her son was in the hospital and was frantic about his welfare. I
asked, if I were to get a prescription for free naloxone sent to our outpatient pharmacy, along
with sending harm reduction education to her house, could she make sure he got them?
“Anything” she said fervently, “I’ll do anything you think will help.” A few things were at play
here in this situation, including a physician who perhaps thought if the patient didn’t want to go
to rehab [though we had other treatments available], they could just leave, a nurse that
possibly thought asking about naloxone or other stabilizing medications was outside of her
scope of practice, and a patient who didn’t have the tools to advocate for himself, ultimately
deciding to leave out of frustration in spite of his recent near-death experience. Again, here are
the three trajectories mingling into a poor care experience. No knowledge or understanding of MOUD availability even in light of the psychiatry consult, no treatment available except for ‘rehab’, and no exhibited lived experience with these patient encounters, even though this was a floor overdose patients and patients with cardiac issues related to injection drug use were often assigned to. Further, I’m not even sure what rehab meant in this context. It could mean a detoxication facility or an inpatient residential facility, both of which don’t typically offer MOUD, and the patient would have still needed linkage to the facility from social work, though I did not see any notes from them in the patient’s chart.

A Routine Process Gone Awry

One drizzly Saturday afternoon, I received a page from a weekend case manager covering the on-call phone. The ED had a patient with a note in their chart that they must return to the Four Pines Recovery Center upon discharge, but the patient told the case manager that they cannot return to the treatment center. The case manager informed me that they “have never encountered a patient that needed to go to a facility for addiction”, and “did not know anything about this process,” “did not know what to do,” that they “knew nothing.” After spending some time trying to explain the process, with the case manager just reiterating that they knew nothing about the process, I finally told them that I would do it myself. I suspect this was the outcome they were hoping for, as they immediately became quite chipper and quickly ended the phone call with a hurried “great!”

I reached out to Four Pines, who informed me that they could not speak to me until the patient signed a release of information (ROI). I let the case manager know we needed an ROI,
and could they please ask the patient to sign one. They repeated that they are not familiar with this process [which I found hard to believe] so I asked the center what needed to be done, and where the ROI needed to be sent. I got a copy of the ROI and the fax number and relayed this information to the case manager. After the patient signed the ROI, I spoke to the nursing staff at Four Pines about the patient’s situation and discovered that it was actually quite a minor issue as to why the patient thought they could not return. We created a discharge plan, which I then relayed back to the case manager, who was very appreciative. What struck me about this situation is that patient placement, either to a skilled nursing facility (SNF) or an assisted living facility (ALF) is the bread and butter of an ED case manager. As soon as OUD crept onto the scene it triggered a full shut down in the case manager who claimed to have no idea what the process should be, even though the process should have mirrored routine patient placement; the only difference lay in the type of facility.

A Shared Helplessness

One of our first BRIDGE patients was screened in the ED around 8pm, and quickly admitted for a related complication. This was the first time that this particular member of the team, A, had enrolled a patient, so unfortunately the chart had not been properly documented with enrollment information. I received a call around 10:45pm from A that the patient still had not received their MOUD and was threatening to leave AMA as she felt we were not helping her. I told A to page the treating physician, who did not answer back. The next step was to page the emergency internal medicine on-call pager, which was being manned by a different physician. This physician refused to order medication for the patient, and referred us to pain
management, even after we explained that the patient had OUD and was not in need of more opioids. I thought a fellow physician may help, so I called one of the physicians who helped me build the BRIDGE. They agreed to give the physician a call, and went over every step of the BRIDGE pathway, including the importance of MOUD. The physician still refused to order the medication, stating they wanted to wait for the a.m. psychiatry consult (though no psychiatry consult had been placed).

I felt quite desperate at this point and called three other physicians who may be able to help. I was unable to reach the first physician. The second physician was on shift in the ED and told me the only thing they could think to do is advise the patient to leave AMA and take the elevator back down to the ED and they would give them the medication. The third physician had some oversight of the on-call physician, and I was finally able to reach them and explain the situation. Fortunately while all this was happening, the patient did not leave AMA, and the third physician was able to reach the on-call physician and make them put in the medication order. While this resulted in several rounds of refresher training for internal medicine, my team and I felt utterly helpless for this patient in the moment. I knew she was sick, tossing and turning in a hospital bed alone, unable to receive the care she needed. I worried she would lose faith in the system we had put in place to care for her, or possibly even the recovery process at large, and decide to just say to hell with it.

I spent a long time mulling over these and other interactions between OUD patients and clinical care teams. What could be at the heart of this sense of helplessness that clinicians had, when many of the patients they see have fairly routine needs, but also the added complexity of
OUD? I was speaking to one physician about these inexplicable phenomena, when they uttered in a contemplative manner, “Well, it’s Sisyphian, isn’t it?”

The Sisyphus Effect

The myth of Sisyphus comes to us from Greek mythology. Sisyphus was condemned by Hades, the God of Death, to push the same boulder up a mountain every day, only for it to roll back down again every night, right before he could get it to crest the top of the mountain. This was his price for cheating death. Twice. In modern life, describing something as Sisyphian has come to represent laborious and futile tasks that produce useless efforts and unending frustrations (Morford and Lenardon 1999). In this sense, the acute treatment of OUD patients becomes a boulder, shift after shift, that you push up the mountain: a patient shows up sick, often primed for a bad encounter because they’re used to not getting the treatment they need. A provider walks into the room, often primed for a bad encounter after opening the chart due to numerous negative experiences with this patient population, who doesn’t have any treatment to offer. Patient gets pissed off, provider gets pissed off, boulder rolls back down.

Q, who has a family history of alcohol use disorder, reflects on this frustration:

Heather: In your practice as a physician, you have this additional clarity or empathy for people that have struggled with substances [due to lived experience]. What have you observed in your peers who may not have had that same sort of lived experience or additional training?

Q: Frustration is the first word that comes to mind. You know, I sometimes say to my colleagues that nobody showed up here to try to hurt people, right? That's not who we are. That's not why we got into this. It [medicine] is way too hard a path to take for that to be your motivation, unless you're Dr. Evil, right? But I think that working, particularly in emergency medicine, there's a sort of revolving door sense sometimes. To be highfalutin about it, there's a Sisyphian kind of outlook, doing the same shit every day,
push the boulder down. You get it to the top, then it comes back down. And then, when your boulder is yelling at you, and weaponizing their IV poll, spitting at you, it changes to something more of, I don’t know, pick your other Greek metaphor, but it becomes something where people are angry, they’re resentful, and I guess frustrated probably wraps it up the most.

Because like I said, nobody got into this not to try to help people. When you can't help somebody that's frustrating. And when you don't have a [lived] perspective on it, you're sort of expecting them to help themselves. I think that's where people get frustrated. And when you lose that empathy, and you have that frustration rise in you, the interaction just degenerates to the point where it's not productive for either one. It becomes oppositional. It becomes a disruption to the department. And then sometimes, you know, people are frustrated or angry or whatever, and they say or do things that they probably shouldn't.

**Heather**: When a patients in that state [of withdrawal], and they're frustrated and angry, spitting and cursing. Why do you think they're doing that?

**Q**: Uh, probably for all the same reasons that the doctor is. So there's a shared sort of, there's a shared experience of helplessness or frustration, like I said, both expecting the other party to do something productive in the scenario, and neither one is, right? Yeah, they're probably having many of the same feelings as the providers. I guess they're brethren in that way, it's just two sides… opposite sides of the track.

I had a particularly salient experience one night with a first year resident physician, someone who was just starting out in their career, that encapsulates this sort of frustration. I received a call from a research associate (RA) who said a current ED patient was a potential candidate for a research study related to OUD, and could I please screen them to see if they meet inclusion criteria. “But I don’t think they’ll stay” the RA said. I sent a text to Q, who happened to be the treating physician, to better understand what was going on with the patient. Q texted back, “How fast can you get here?” Why, what's going on, I asked? My phone started ringing.

Q related that Luis, a male in his late twenties, was found unresponsive in a friend’s car, and was brought in by ambulance. Luis had overdosed quite severely, needing an unusually large dose of naloxone in the field en route to the hospital. “He wants to leave AMA, and I’m
not sure how much longer I can stall him,” Q said rapidly into the phone, “Can you please come help me? This guy will die tonight if we don’t do something.” I knew the medical consequences of Louis leaving AMA. The naloxone he received in the field has a half-life of 30-45 minutes, after which respiratory depression returns, with one of the next steps being cardiac arrest. “Give me fifteen minutes,” I said. Fortunately, I was around the corner from the hospital studying, and had my work jacket in the back of my car. I threw it on hastily over my street clothes, and rushed to the ED. When I walked in, I went straight to Q’s area, and found Louis on my way; he was perched on the edge of a hallway bed, eyes roaming the corridor. He was telling a nurse that he wasn’t interested in linkage to care or treatment, saying that it’s not a problem, "because I just used once."

I could tell this was a tense situation, and I wanted to build some rapport with him, so I slowly walked up and said, “Hey Louis, I’m from the MOUD team, can I sit down and chat for a minute?” as I wheeled a small black stool over to his bed. “It’s like I already told her,” he said, gesturing to the nurse, “I just got out of jail. I just wanted to party one more time, I just used once. I’m fine because I won’t do it again.” What Louis didn’t know before he went to party with his friends was that his time in jail had erased his tolerance to heroin, and his usual dose (which was a lot), instead of resulting in a good time, resulted in a severe overdose. “Look, I don’t care if you use again; you could use again tomorrow. I just want to keep you alive tonight, can you help me keep you alive?” I must have looked exceptionally earnest; Louis slightly nodded his head and eased back onto the bed a bit and allowed me to explain the process of what had happened to him, and why it was so vital that we made sure he left the ED with additional naloxone. At this point you could see recognition of the severity of his situation
dawn in his eyes, and he agreed to wait while I got no-cost naloxone ordered and grabbed our harm reduction and rescue breathing education.

When I went back to the pod, Q told me the pharmacy said it would be fifteen minutes to fill, but we didn't have fifteen minutes, and could I go back to hurry the process? I headed back to the satellite pharmacy and rapped on the glass, where there was a slight woman with tawny brown hair and oversized glasses slowly sliding down her nose, staring at a computer. I called her over and explained that the naloxone prescription was for a patient who nearly killed himself tonight on a high dose of heroin, who now wants to leave AMA, is there anything we can do to hurry the process? “I can only go so fast. And Q wrote the prescription wrong, the quantity isn’t one, it should be two,” she said, flustered. I assured her it was ok, that I understood where she was coming from. “I’ll just stand near the window so I can grab it as soon as it is filled,” I said as I leaned against the opposite wall. Around three minutes later, she handed me a bag of naloxone out the pharmacy window, and I apologized for being a pain in the ass.

I jogged back to the pod to give the medicine to Louis, who already had his IV removed and was standing to go. I gave him the naloxone, taught him again how to use it, and reinforced the risk of the respiratory depression coming back. “Do you have someone to sit with you tonight, who can administer the naloxone if they have to?” I asked him. “Yeah, yeah, my buddy and I are driving to Ocala tonight, he’ll be with me.” “Ok good. If this [heroin use] ever does become a problem, or you need anything at all, please come back to us for treatment.” He nodded, and turned to go, clutching the naloxone, as I walked back to the pod. “Did you get it
done?” Q asked as soon as I came around the corner. I nodded. “Hell yeah, we just saved that dudes life!” they exclaimed as we high-fived.

I noticed the resident physician that evening, N, staring at us with a guarded expression. I turned, and they said "He [the patient] has decision making capacity, if he wants to die then he can go die." “The disease process of addiction is a bit more complex than that," I said, probably doing a poor job of masking my shock, while Q nodded in agreement. “ I mean, he's not high anymore, right? He can make decisions." N said defiantly. “Perhaps, in the broadest possible sense of the term, but the clinical concept of decision making capacity in this specific situation does not provide a very clear picture of what may be going on with that patient.” N offered a semi-disgusted expression and swiveled their chair back to the computer screen.

In that moment I decided to leave the pod and go get a soft drink, before I said something unprofessional. I sent Q a text from the cafeteria, commenting on N’s poor attitude, which I later discovered was a main driver in Louis’s decision to leave AMA. This particular instance resulted in increased training and mentorship with the resident about our hospitals values and commitment to treat patients with OUD, and a return visit from Louis to be enrolled in our BRIDGE pathway. Encounters such as these highlight the general attitude of defeat towards providing care for OUD patients that plague some physicians, even at the beginning of their careers, as well as the key role that satisfaction with care plays in successful (or unsuccessful) patient outcomes.
Patient (dis)Satisfaction

According to a 2017 report on patient experience [re- satisfaction], “strengthening the relationship between healthcare providers and their patients will lead to earlier detection of diseases, better patient compliance, reduction of cost, and improved clinical outcomes, among other benefits” (CMS 2017). Prior to this report, five key areas were identified to create a positive patient experience: 1) making your practice look and feel engaging; 2) honor patients with respect and attention; 3) improve communication at every step of the patient visit; 4) commit to timeliness; and 5) make ease-of-access a top priority (Capko 2015). During an ED encounter, trying to meet all of the clinical goals and administrative metrics required of the physician in an ever-shrinking time window, often clinical checklists are relied on to “effectively address what would appear to be intractable, complex and potentially painful structural issues” (Catchpole and Russ 2015). While at face value, checklists seem like a miraculous solution, they do not always “reflect an understanding of the problems needing to be solved, how best to solve them or indeed the intricacies surrounding the implementation, use and impact of such a simple looking tool” (Catchpole and Russ 2015:1). This approach, especially for OUD patients that are used to being categorized as high risk, can make seeking care seem like an unending journey of checklists without any real compassion or solutions.

Shelia, an injection drug user with a medical history of recurrent sebaceous cysts, reflects on her visits to the ED for care:

**Heather:** When you go to the ED [for your flare ups], how does it seem to you in terms of the questions you’re asked?
**Sheila:** God. You need to do this, and you need to do that. And I see you're still smoking. So you need to stop that. And you're like, just like okay, well tell me how? Yeah, it's like if you only knew right now. I mean, I don't tell them everything, you know. It's just a checklist, right? Oh, do you smoke? Do you do drugs? Have you ever been abused? And you're just like, no, no, no. Nope. No, I have no idea what you're talking about. [physician] But you smell like cigarettes? Oh, it's my mom, I told her to quit smoking. You know?

Of patients interviewed, 40% shared how they felt their ED visit just came down to a checklist. My observations of ED encounters support this, where the clinical team need specific questions answered, but there doesn’t end up being much room for an actual conversation. Further, multiple members of the care team have the same or similar questionnaires they need the patient to answer, leaving the patient wondering if the care team communicates with each other (Villalona et al. 2020). Often, patients reported that physicians spent less than two minutes of actual verbal interaction with the patient, and then they did not see them again. The complexity of this patient population necessitates more than a two-minute interaction, especially when there is not a formal mechanism for treatment.

Here, a recovery of low-context communication could be extremely valuable (see chapter three). Ultra-short interactions between the physician and patient, or encounters where the attending just sends the resident in to deal with the patient, speak to both the administrative constraints the physician is under and the lack of viable treatment options for this population. This often leads to patients becoming dissatisfied with their care and coming back to the ED hoping for a different outcome (and doctor). Joe, a patient who has sought help for OUD multiple times at various EDs, explains that he spends days working up the courage to come, but usually ends up leaving AMA:
Heather: When you go to the hospital [for OUD], how is it usually? What sort of care do you receive?

Joe: Well it’s just a list, ain’t it? They don’t even look at you, they just go down their list. And especially when you’re there for that [OUD], they, you know, that’s when they start treating you like a scumbag. Like I was a real lowlife, you know?. I’ve been in the ED so many times before, asking for help. And they’re like, well we’re not giving you nothing. So I’m like, what? Then I gotta leave [because I’m sick]. You know?

To further complicate matters, multiple systems often converge on this patient population, complicating their lives and altering their trajectory (which often leaves them the worse for wear). Sam, one of our BRIDGE patients who needed multiple ED enrollments before reaching a stable point of recovery shared a particularly jarring experience he had with the criminal justice system during his active use:

Sam: I wish I didn’t have [all] the felonies and the tattoos. I could get a lot better job.

Heather: Oh, long sleeve shirts will fix the tattoos. I don’t know how many felonies you have, but have you ever tried to get them expunged?

Sam: No, I wanted to... I went to prison one time and it was, I shouldn’t... I shouldn’t even a went, it was terrible. For a vacuum cleaner. It was crazy. It was a crazy story. I sold a vacuum cleaner on Offer-Up that someone had sold me that... I knew it was probably kind of stolen. They [the police] got me with dealing in [trafficking] stolen property. They charged me with a 15 year charge. An A class [felony].

Heather: That is insane!

Sam: I was like, you got to be kidding me. I was like, you know, it’s crazy. For a fifty dollar vacuum?

Societal notions of licit versus illicit drug use repeatedly separate people who use substances, vastly altering life trajectories, with the culmination of that alteration comprising many OUD

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13 A person is only charged with felony theft when the item(s) stolen are equal to or greater than $500. This is the reason Joey was charged with trafficking stolen property, as the mandatory minimum sentence is much higher for this charge.
patients that come to the ED for care. It can be difficult for a physician [particularly without lived experience] to understand the complexity of these patients, often wondering ‘why they just won’t stop using drugs’ or ‘why don’t they just listen to me’? Don’t they care about their health? Before jail or multiple ED visits, however, it is important to start with exactly where someone who parents with wine versus someone with prison time for selling a vacuum cleaner’s life trajectories diverge.

So How Did All This Get Started for You?

After verbal consent and pleasantries, most chats with patients about their drug use usually opened with the question “So, how did all this get started for you?” I wanted to leave enough room for them to start at whatever point in their narrative they felt resonated most closely with their current struggles with opioids. Every patient started, unprompted, with their childhood. Shelia relates how her issues with opioids began during a routine visit to her primary care physician after a back injury:

Shelia: You know, it’s funny. My mom was like [a straight arrow] you know, and my dad was an alcoholic. So I stayed away from the alcohol, I was like oh no, I don’t want to be like that. Let’s go [with] the hard stuff. [laughter] I started out with smoking crack, my daughter is [here too] and unfortunately, she followed in my footsteps and it hurts. I had her when I was 16, so I think I was like 20 or 21 and then I had stopped for a number of years. Now. But I fell with her baby and I hurt my back. And the doctors were like here, try this. Here’s 50 Percocet’s, right? I’m like, okay, this is cool. And have been using opiates ever since.

Heather: Did the doctor ask you anything about your history before they prescribed the pills? Like if you had a family history of addiction?

Shelia: No. Of course they didn’t. No, he gave me 50 of them [Percocet’s], he gave me 120 Lortabs, and 30 of the Oxycodone 30 [mg]. He never told me I’d be addicted to them. Because I’ve been in and out of the hospital, I have sebaceous cysts anyway so
when I get an abscess usually I can just pass it off as that, you know. I don't like to, but you know [what else can you do]?

Patients reporting receiving no information about the addictive quality of opioids is an all too common problem, especially in Florida\(^\text{14}\). This absence of previous medical education often creates an anger of sorts toward the physician where patients feel like ‘you gave me these pills, and now I’m addicted, and you won’t help me’. But with each new physician a patient sees that particular physician didn’t create the problem, and certainly has not had the answers to solve the active addiction, as opioid use education is a largely preventative measure. Answering this same question of “how did it start?”, Drew reflects on his childhood, where he snorted heroin for the first time in elementary school:

Drew: When I did it [heroin] the first time, I was young kid and I was you know, selling dope. My dad sold dope. You know, I was like you\(^\text{15}\), [laughter]. I grew up in [a farming community] in a trailer that was a trap house, a shooting gallery\(^\text{16}\). I’ve seen a lot of people die, and not come back [from a young age]. At ten, twelve, you know, I seen them… they just died.

This was an extremely common theme among patients, with 65% discussing a family history of drug use, which speaks to the generational aspects of addiction. I would leverage this information many times to physicians to peel back the curtain on how structural, societal inequalities affect addiction, with the goal of diffusing frustration toward OUD patients for being ‘non-compliant.’ One story in particular that I lean on is from my time as a methadone

\(^\text{14}\) For more information, refer to articles such as “Florida’s ‘Pill Mills’ Were a Gateway to the Opioid Crisis” https://www.usnews.com/news/us/articles/2019-07-20/floridas-pill-mills-were-a-gateway-to-the-opioid-crisis?context=amp
\(^\text{15}\) Drew is referring to the fact that both their parents and mine sold drugs.
\(^\text{16}\) Trap house and shooting gallery are euphemisms for a place where drugs are sold, and a place where people congregate to inject drugs, respectively.
clinic counselor intern. On my list of patient sessions to sit in on for the day was an 18 year old young woman with fiery red hair and an easy smile. In speaking with her about what is going on in her life and how her treatment is going, her phone begins to ring. She looks at me as if to say, “this phone call will answer your question.” When she answers, her mother is on the other end of the line screaming at her—“you bitch, I know you’re at that fucking clinic today. You fucking sell out.” I turned to her with wide eyes as she hung up on her mother. I was informed that one of her mother’s many boyfriends had held her down in a bed when she was 14 and injected her with heroin. Her mother wanted someone to party with... and she had either been injected or injecting on her own ever since. This patient was desperately trying to enter a system of recovery as soon as it was legal for her to do so, but structural and relational ties were severely affecting her chances of success. One physician I related this story to gaped back at me, slack jawed. “Heather, if you had not just sat here and told me this story I would have never believed anything like that could be possible” they said. Following the same theme, Kathy thinks back to the dissolution of her teenaged marriage:

**Kathy:** Yeah, I mean, I had bad back pain after having twins [as a teenager]. I had surgery, and kind of like, the standard thing [for that] was pills. So, I started taking prescription pills and got addicted to those. Then I went through a divorce, and there was all this extra trauma, and freedom at the same time. I had three little kids but they were becoming older, and then I had them gone all the time. So I met my boyfriend, and I was like, okay, I haven’t been able to go out of the house... which was a stupid decision. I kind of always liked cocaine [from a young age], so it really kind of snowballed from there. And then eventually, I think everybody gets the point [that] you start using needles, because you need more bang for your buck.

Here we see similar structural, environmental, and medical education issues converging for this patient. A common adage in addiction treatment is “people, places, and things” which is to mean that in order to successfully recover, you must change the people, places, and things in
your life. However, sometimes when these things change without the appropriate structural support, recovery begins to spiral. Nearly all of the patients in this study shared with me that they did not have the necessary structural supports during crucial developmental ages. Josh thinks back to when his father would disappear for days at a time when he was a teenager:

**Josh:** So basically, my dad was a heroin addict, you know. And at 16 I did it [heroin] the first time. It made me sick that first time, but then I started doing it every day at 18. You know, because I found it in my house.

**Josh:** My mom, she just retired as a detective. Twenty five years as a sheriff. And then it’s weird, her and my dad divorced. And they were actually... it’s so crazy. They were evangelists, they travel all over the world preaching. That's how I grew up. Then at 12 they split up, she became a cop, and he [my dad] relapsed. Went back to shooting dope after twenty-some years clean. You know, so then I was around that, but I was in denial forever. People are like, "Man, your dad's gettin high." I’d say, “no he's not”! He'd be standing in from of the TV, bent over at the waist. And I was like, no he's just tired! Super, super tired. Really tired.

**Heather:** He just hasn’t slept in days!

**Josh:** [laughter] Right. He would just stand there, because of course we lost the remote, you can’t find them for nothing. So he’d just stand in front of the TV, just bent over. And then he’d go to the casino. And I had nobody watching me, so I was the really cool guy in school, that we could all just go [to my house] and party. He would go to the casino for like, three, four days at a time. Work, go to the casino, work, go to the casino. Sleep in the parking lot of the casino, then go inside. So he went from being a preacher to doing that. So like I said, I was the guy everyone brought all their drugs to, their girls, or whatever. And my little apartment was jumping. [laughter] Boy, that thing was, you know that's where it was at.

**Heather:** The spot.

**Josh:** Yeah, that [apartment] was the spot. He would give me my little money for the week for lunch and gas money for my car. Yeah, it was... it was a fun time. He really was a fun guy. But you know the fun times as a kid leads to bad times as an adult, you know, and you realize you wasted so much [of your life].

Even in these brief histories, this story, the observation, “I’ve wasted so much of my life” or “doing drugs was a stupid decision,” replicates a broader narrative of choice and
responsibility, showing how these narratives even cloud the reality of addiction for patients themselves; it is ever-present in the user’s mind, ready to tear them down at a moment’s notice. I spent some time talking with Josh about his childhood, and how it most likely contributed to his OUD today. “Man, I thought that! I thought that. I told the counselors here [at Stony Vale] that, and they said I was just making excuses, that I must still just want to do dope. I’d get clean when I stopped the excuses.” Not only does reflecting on how experiences of trauma contribute to addiction catch OUD patients unawares, but it is also something that is contextually missing from the average ED encounter, where a physician opens a chart to read the patients history and formulates an assumption that they are just there for pills, or ‘drug seeking.’

Enduring disadvantageous situations or childhoods like the ones described above, while the brain is still in active development, can alter a person’s life trajectory completely, hindering brain development and making a person much more at risk for developing a substance use disorder (Dube et al. 2003; Tilson 2018; Gong 2020). Further, a significant portion of these children go on to develop issues like complex PTSD from their experiences (Brockie et al. 2015), which comes not only with mental challenges, but physical challenges as well. Recurrent nightmares, hypervigilance, anxiety, depression, and more can lead a person to self-medicating with substances in order to quell these physical symptoms. Couple this with a lack of understanding regarding how their experiences have affected them mentally and physically, and a lack of understanding on how opioids function physiologically, and you more than likely are going to end up with a person developing OUD.
This nuance is missing from clinical encounters, and the dominant social narrative tells us that people are choosing to use and are generally wasting time and resources with their recurrent ED visits. I spent a significant portion of time sitting down with patients to explain the connection between structural instability and drug use. Most patients would break down in tears. “Really? I thought I was just a piece of shit” they would say, or “This makes so much sense, I was getting to the point that I didn’t see a reason to live anymore, I just couldn’t get it right.” As if by validating their experiences and the effects they have had on their lives, this gave them permission to live again, to allow them to realize they were worthy of seeking care for OUD. As patients often fail to understand how their life experiences contribute to their current situation, this is also coupled with a lack of provider knowledge on the physiological trajectory of drug use, where tolerance is working against the user from the outset. Each new high is just a bit less impressive than the last, until eventually, the user is just trying to ‘get right’; some have trouble remembering what the high even felt like.

**Drug Seeking vs. Dope Sick**

A quick google search for “the drug seeking patient” returns dramatic headings meant to assist the average physician in determining if the patient before them is legitimate or not: “Prescription Drug Abuse and the Drug-Seeking Patient, don’t let drug seekers obtain prescriptions (Behnam and Rogers 2008)”; “13 Red Flags your Pain Patient is a Drug Seeker, don’t complicate the opioid epidemic” (Girgis 2017); “Don’t be Scammed by a Drug Abuser, telling the difference between a legitimate patient and a drug abuser isn’t easy” (DEA2021); the
list is endless. A popular Reddit forum, r/emergencymedicine, has an entire thread for fanning away the fog of a drug seeker smoke screen. User Reddit1 writes:

*I look at all their charts. Bingo, there is the narcotic/benzo/stimulant. Asking for any of these drugs [listed] from a provider= this consequence... [I] spin monitor to patient. Stare at patient. And then they either take what non-drug group listed alternative [I offer them] or they leave. Next patient. HARD NO. I do not know you. I do not give narcs/benzo/stimulants to patients not established with me. Had a guy flip out I wouldn’t give him IV narcs for home use. [in my] head- “you can leave quietly now or in the back of a squad car.”*

Another user, Reddit 2, signals the way around this is to make it known you’re not a push-over; “Any new job you get pestered for 6 months till it gets out in the community you are not an easy touch, if you mess up and are conned... cue drug seekers for weeks”. User Reddit3 an EMT, shared their uncle’s philosophy:

“My uncle told me he’s a brick wall when it comes to drug seekers....most will ask for something for pain....typically when Advil/Tylenol won’t help there should be some concern.....especially considering there is acetaminophen in Hydrocodone. The old ‘oh doc Tylenol rips my stomach apart can I have Vicodin’ and my uncle’s response is the old adage of ‘if you know what you want you aren’t getting it.’”

I made it pretty far down the board without seeing a single mention of offering some sort of treatment for the addiction itself. Reddit4, a nurse, does chime in that “it is much more ethical
to give a drug seeker their fix of Dilaudid, than to be jaded and deny someone who is in real pain the relief they need:

“Back problems are one of the worst because as soon as you say your back hurts everybody instantly assumes you’re faking it to get drugs. I occasionally do something to my back (I honestly have no idea what it is and it’s too intermittent for anybody to diagnose it) where I suddenly have an excruciating amount of pain, so much I can barely move. It only lasts for a few days, which is never enough time to get an appointment and see a specialist. Going to the ER is useless because they instantly assume you’re just a drug seeker. Well fuck off, I don’t care if 500 people a day come in to get high off Vicodin, give me something so I can move!”

Seemingly they offer this due to the lived experiences they have of seeking care and being labeled and denied. These are not isolated attitudes either or outdated; each post was within the last 18 months. I have seen similar attitudes in my field site as well. The root of this attitude may lie [at least partially] within Reddit4’s assertion. Someone in real pain. What does this mean? Is someone in withdrawal from opioids not in real pain?

What we see occurring here is a clash of frameworks, where providers are utilizing their current knowledge and perceptions of drug use, as well as advice from their colleagues to form an opinion about patients that are “safe” to prescribe opioids to, versus those who are not. But patients coming to the ED in opioid withdrawal are more often than not in excruciating pain. As one patient puts it:

“Man, they just don’t understand. When you’re dope sick, you’ll do anything. Anything to get right. There’s 2 steps to heroin. 1) using to get high 2) doing anything to get right.”
You don’t care about friends, family, no one [when you’re sick]. You’ll see somebody you’ve known since elementary school, and say ‘Hey man, you got five dollars?’ You turn into a different person... someone you don’t know.” (Personal Communication, 2021).

The outcome of this ED encounter is often like touching two live wires together. Both provider and patient have differing expectations about how the encounter should go, as well as copious miscommunications about what the other should be doing. Multiple people shared their near-constant fear of being dope sick, an all-consuming thought from the time they open their eyes each day until they are able to find some form of opioids to resolve their withdrawal.

**Heather:** Have you ever tried any MOUD, like methadone or buprenorphine [Suboxone]?

**Paty:** Yes, and it helps. I mean, I would definitely get back on it. But I couldn’t afford it anymore [but] I can’t keep affording to use... I worry all day. It’s pretty much every day, like, when are we going to get our next high? Or I’m starting to get sick. When can I not feel sick anymore? My boyfriend doesn’t ever feel any high anymore, he just doesn’t feel sick. He's only doing it [heroin] so he's not sick, right? I hardly ever feel it [the high] anymore, but then sometimes I do feel it, and that's what keeps me wanting it more, still wanting it. But at the same time, there’s times where I don’t, and the shooting up, you know, it’s in my hands [gestures to wound]. I mean, it’s just it's terrible. In my neck [gestures to wound on neck]. I’ve been wearing my hair down this whole day because I started going in my neck. And it’s not like I have any misses or anything, it’s just going... it’s just going over and over in the same place. Right? It's embarrassing. I don’t want to live like this.

This concept of using but not feeling high is well-known in the drug community.

Physiologically, opioid users begin to build an immediate tolerance to the drug, which ebbs and flows along a continuum until the user no longer feels high but uses to not feel sick17. I

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17 In the community, this process is known as ‘chasing the dragon’; you will never be as high as your first time using heroin, and the high essentially decreases each time until it fades entirely.
observed time and again this lack of physiological awareness of addiction with ED physicians.
The moral model of addiction, however, often overshadowed any sort of biomedical reasoning about the physiological process the patient was experiencing. “It’s not my job to get them high” I would hear, or “they choose to get high, if they didn’t want to get sick they would stop shooting up” or, “they chose this so they can sit there, it’s not like withdrawal is going to kill them”. This binary stigmatization often robs the OUD patient of legitimacy and agency, keeping them away from seeking care again even if they are gravely ill. Greg, admitted for a serious infection, shares how desperate he is for his girlfriend (who likely has the same infection) to come to the ED, but the fear of being dope sick keeps her away:

“She just sleeps all the time. You know, she has a bad medical condition. She really needs to come [here] but she doesn’t want to go [to the doctor] because she’s scared she’s gonna get sick. If she gets sick, and the hospital keeps her... she's just terrified she's gonna get sick” (Personal Communication, 2020).

Tim, one of our BRIDGE patients on a stable dose of methadone, says he wishes doctors would understand how it really is for someone addicted to opioids:

**Heather:** So when you’re using [heroin] you’re just returning to baseline? Your normal everyday self?

**Tim:** Yeah. It actually gives me a little bit of energy. I feel like I had a cup of coffee or something. I mean... I feel very, I feel more alert. I don’t nod out. I don’t even get high. I just feel normal. But that withdrawal [shakes head]... that’s what gets you. That’s when you’re on deaths door.

This mismatch of frameworks is a critical intervention point in emergency medicine, where addiction training, a nuanced understanding of how opioids affect people differently, and a
treatment that can be offered to patients has the potential to save lives. One of the most accessible places to start this training is with a more comprehensive education on the tolerance, dependence, and withdrawal process of opioids, and the reality that opioid withdrawal is real pain that needs to be addressed. Giving someone MOUD in the ED is not helping them to get high, it is the stabilization of an acute, physiological crisis.

**Downstream Treatment Frustration**

A drug seeking attitude isn’t exclusive to emergency medicine. It trickles into downstream care as well, coloring how patients are cared for across the continuum, which speaks to the larger social narratives around a legitimate opioid user versus an illegitimate drug seeker. Community treatment is often structured around this drug seeking mentality, and set up in a punitive manner, right when a person is begging for treatment—just trying not to be sick and put the pieces of their life back together. During an afternoon conversation with a patient we had enrolled into the BRIDGE three times already, he let me know as I sat crinkling on the adjacent hospital bed that the only times he’s ever stopped using [heroin] is in the hospital or jail.

“I’ve seriously OD’d four times. Not sure how much longer I got. But the pull to use is just too strong. It’s mental. The pull drowns everything else out. I know you enrolled me [before] but I didn’t show, none of the times. It’s not your fault. It’s just... treatment programs are like jail. And jail doesn’t rehabilitate you, it just teaches you how to be a better criminal. You’re surrounded by users just like you, so it’s hard to get clean. There’s always people in the program that’s dealing, so you don’t stay sober, you just figure out
how to use around the rules, or straight relapse and leave the program. (Personal Communication, 2021).

Further illustrating this point, Michaela, back in the ED for a recent relapse, doesn’t understand why drug treatment seems to mirror probation so closely.

“I don’t care to go to Four Pines again. I felt like I was on probation. You know, if you expect to dose, you’re not supposed to use any other drugs, ever. Total abstinence. They watch you, make you drop\textsuperscript{18}, go to classes every day if you relapse, it’s just… it was crazy. I’m like, how do you expect me to have a life? I’m just trying to be, you know, on methadone here. I got small kids at home. They wanted me to go to relapse prevention classes and see a counselor multiple times a week. I don’t even have a ride. It was like, really serious. It really felt like I was on probation (Personal Communication, 2021).

When treatment is structured in such a highly regimented and punitive way, it can often lead to staff that are ‘just following the rules’ with no room for any sort of flexibility for unique situations. Instead of functioning as safeguards, rules that aren’t regularly re-evaluated eventually become barriers to care. One Monday afternoon, I received a call from Jamie, a recently enrolled BRIDGE patient, to let me know that the treatment team at the center we linked her to wouldn’t listen to her about her withdrawal symptoms, saying she was just looking to get high.

\textsuperscript{18} The term ‘drop’ or ‘dropping’ is a colloquial term in addiction treatment for taking a urine drug screen.
“Well that’s what they tell me here. That I’m just trying to get high. Downstairs when I tell them, I say, listen this dose is not enough. When I come in, especially since they changed dosing to the afternoon. I come in the next morning, my back is sweaty, my nose is running, my stomach is killing me. I don’t feel good... you can tell. And they say, "Don’t lie, you feel fine! Methadone lasts 48 hours!" And I’m like no, it don’t last 48 hours. I mean lately it doesn’t, [because] I’m active. I work out a lot. I’m in the gym. And what really messes me up is the flip flopping, dosing in the morning then dosing in the afternoon. It feels like a long time. I don’t think you should be changing all the time when you’re dosing, you know? I just wish they’d listen to me about how I feel. If I wanted to go get dope, I’d go get dope. I’m here trying to stay clean.” (Personal Communication, 2021).

This process can become exhausting for people that are just trying to stay off of drugs and maintain some semblance of a normal life. Tanya tells me she may have lost faith in the whole process altogether.

**Tanya:** I've seen all my friends go through drug court. AA. NA. CA. All that shit doesn't work. And then we don't have money, we don't have health insurance, we don't have a car, you have to go every four days when your color calls to drop, like... we're just criminals. But none of it even works! Where's the human being in all this. You go to the methadone clinic, and to be honest with you, I think it's there for more money now than anything. Either that or they just don't care. There is no interactions anymore, it's like okay, time for you to drop. Okay, you're dirty, that's it, [get out].

**Heather:** It's just another checklist?

**Tanya:** You're right, you're absolutely right. Where is the humanity? Where is what you're trained to do?
Sean shares a particularly harrowing few years, stuck in a cycle of relapse and recovery, where he was afraid to start MOUD again because if he made a mistake he would be kicked out of the program.

Sean: I got back [on methadone] when I was 19. I was dosing around 150 milligrams there. And that was good. Because I had a high tolerance even at a young age, I had a high tolerance. Then I relapsed real bad. Because my fiancé died. I was actually a director of the rehab program then... it was a faith based rehab. But I got myself together again, [got back on methadone], then relapsed again. Lost a child. It was another traumatic experience. After that I caught charges, went to prison. Relapsed again when I got out.

Heather: Does the methadone work for you?

Sean: Yeah. Yeah it works great. But when you relapse... they staff you. They say you can’t come back. Only time I ever did good was on methadone. But this last time, when I relapsed after getting out, I was very much adamant against the MOUD program. I was adamant against it, you know, like—no, I'm doing that again, it's a setup.

Even with extensive training, increases in emotional intelligence and empathy, and an increased structural understanding, if there is not a tool physicians can use, or a treatment that can be offered then the frustration is not resolved during an ED encounter, either on the part of the provider or the patient.

Understanding Without a Tool StillEquals Frustration

One of the main themes I uncovered during my time observing and having conversations with physicians was this sense of frustration and burnout around caring for OUD patients. Not that they don’t want to care for this population, but that there was no care available to give them. Imagine you see an issue [like addiction] every day, day in and day out, and this issue is pervasive with life altering consequences. Your job says this is an issue you are
supposed to be there to help fix, but you have no fix to give. Something like that wears on you; it grinds you down. It can cause you to do things out of character, transform you into something unrecognizable. Additional knowledge and trainings on the issue do nothing to quell the frustration felt at being powerless to effect any meaningful change. Sometimes, these out of character actions happen during training, where impressionable colleagues are coming up through the ranks, looking to you to shape how they go on to practice medicine. One provider shares a formative experience they had on a ride-along in the field during the early days of their training that captures this helpless frustration.

“I remember one formative educational experience. I was probably 19 years old, and I needed a ride-along with a police officer to finish a certification. We had a dude who was running [from the cop] and had swallowed a bunch of crack so that he wouldn't get arrested. Because the guy had swallowed so much crack, we had to call an ambulance, and the medic decided to punish him for it. I remember they pulled out the biggest, fattest needle they could find, and jabbed it around [in the patient] a bunch. And initially, I was kind of going along with their sort of interpretation of it. Well, he's a junkie and, you know, he's a criminal, and, you know, this'll teach him kind of thing, right? And then, at some point [during the encounter], I don't know exactly when, but at some point, I didn't want to be there anymore, because I was sort of ashamed [of what was happening]. Because I thought that was a terrible thing to do to somebody. And all these years later, I still see that [frustration] in the ED. I see it happen all the time. That sort of frustration for something you can’t fix causes people to say and do things that they shouldn't, to lash out. And it’s probably no different for the patients. Because it's the
same [frustration]. Sometimes [for physicians] it’s ‘like well, you did this, and you came
to my ER. So now I’m going to do this to you [because] now, you’re my problem. And I’m
pissed off that you’re here’. It’s just when you see something over and over again, and
there’s nothing you can do about it... the frustration [it] changes you. It can change how
you practice medicine (Personal Communication, 2021).

When you are tasked with caring for a patient in front of you, and you know that there
is nothing you can do for this person, it can strain the rest of your ED shift; eventually it starts to
color the way you see the world. What can you do when you are trained to care for people, in
an unequal system not designed to care for all? A resident physician shared with me their
frustration about the incongruence between what they learned in medical school, versus the
reality of caring for an unfunded patient.

“I recently tried to get a patient in the ED cancer care. I was trying to get them a biopsy
but they were unfunded. So that means there was no way that they would get a biopsy,
and there was no way that they would get established [somewhere]. This is one of those
situations where I feel forced to be disingenuous. I can give this person follow up, but I
know they’re not going to get an appointment for months unless they have insurance.
So... my textbook says, discharge and outpatient follow up, and I can give them all the
phone numbers to do that. But I’m fairly conscious that if I go through with that, there’s
no implementation and follow through to help this person, because there’s no systems in
place. So my next option is, I admit them, and you try and strong arm a specialist to get
a biopsy. And I think the exact words [from the specialist] were, ‘Okay, who is the
internal medicine person that placed this consult, I want to know why we’re doing charity on the weekends? And I wanted to reach through the phone and grab them and place them in a chair here [in the ED]. Like, on one hand, I can understand where he's coming from. It’s a weekend, and I just asked him to do something that's not indicated in the patient. On the other hand, you need to sit down and check yourself, this is a person’s life... during a shift there's no way to take yourself out of that moment (Personal Communication, 2021).

These examples demonstrate the vital need to have systems of care in place for complex OUD patients to circumvent a shared experience of frustration between patient and provider, where both are going through the motions of care, with both understanding that no care will come. In the next chapter, I will discuss the ethnographic outcomes of implementing the MOUD pathway, and how the pathway has changed seeking and providing care for OUD in the ED.
Chapter Five

BRIDGE: An Ethnographically Informed Treatment Pathway and Changing the Acute Care Management of Opioid Use Disorder

While the following chapter of this dissertation reports quantitative patient outcomes and functions as an ‘implementation roadmap’ for how clinical interventions can be built utilizing applied medical anthropology, the aim of this chapter is to break down the why behind how the BRIDGE pathway became a standard of care in the emergency room, along with documenting the impacts and changes experienced along the way by providers and patients. First, providers shared with me that before the BRIDGE pathway, the only thing they could do for a patient with OUD was try to work a broken system, while now they feel there is meaningful care they can offer. The brokenness of this system is extensively explored in chapter four, including a lack of treatment options, a lack of downstream care, and a lack of clinical understanding about addiction.

Next, I explore patient’s experiences after participating in the pathway, understanding how their care has changed post-pathway implementation, along with the effects of integrating people in recovery into the clinical care process. I then discuss the process of building something new that looks the same as pre-existing pathways (such as those for sepsis or heart attacks), which exponentially increases the odds that the new pathway will become absorbed
by physicians and clinical care staff as a standard of care. Next, I share provider reflections on what they believe is important regarding pathway implementation to address OUD in the ED, and how the BRIDGE pathway has changed the way they practice medicine. The end of the chapter considers a concept known as a ‘sentinel event’ in medicine (Kinnan 2006), where I discuss the event at the hospital that ultimately led to the BRIDGE pathway becoming official hospital policy.

From “Working the System” to Meaningful Patient Care

Providing patient care today requires a high level knowledge of systems (Rodin et al 1978; Kleinman 1978), where multiple actors are coming together in a constant state of complexity and flux. I consider the trajectory framework to be highly relevant to systems; complexity arises when actors encounter multiple factors throughout their lives that shape their individual frameworks, then those actors intersect in myriad ways with both each other and institutions to create multi-layered experiences that clash and coalesce again and again as patients seek care for OUD. A way to break this down is to think about the three systems that are interacting with one another during a typical ED encounter.

First, you have the providers system, which is where physicians are providing care and support for patients, conducting administrative tasks, and completing other processes of care. Second, you have the healthcare system, which comprises the ED, the hospital the ED is in, other clinical programs and centers, specialists, and others that integrate into that particular health system. Then you have the patient’s system, which is comprised of family and friends, community organizations, primary care providers, and other healthcare systems (Henry 2019).
What do you do then, as a physician, when you have a good working knowledge of your particular system and how your training tells you patients are supposed to navigate through it, but also an understanding that the systems you are attempting to move through are fragmented and non-functional? Before the BRIDGE pathway was implemented, physicians relayed to me that they got “pretty good at working the system” and “moving OUD patients through” [to discharge], but they weren’t necessarily offering any sort of meaningful care. One missing piece to this puzzle is a lack of clarity on how downstream treatment functions. A community treatment provider reflects on how the BRIDGE pathway has affected a previously defunct relationship, which allows them to provide better patient care.

“I’ve worked this system for so long, and we found ways to work around it. But there was always this kind of frustration, about not being able to get people with OUD seen [in the ED]. Now patients are getting treatment, and then coming straight [here] from you guys, which is awesome. Because for some of them, it is like, if I don’t get them into somewhere immediately, then they are going to go use, they are going to go shoot up and we just have to hope they don’t die. So being able to say, hey, you can go to the hospital, and know that they’re actually going to get help [is incredible], instead of just wait and come back to the center tomorrow.”

As the BRIDGE pathway was designed, there was an integral focus placed on active communication between the ED treatment team and the community treatment provider. A

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19 Downstream treatment is referred to as treatment patients receive after they are discharged from the ED. Upstream care would be care they received before visiting the ED.
community provider reflects on how things have changed since the pathway integrated the two systems in this way.

**Heather:** Obviously all healthcare systems should talk to each other. That's the goal. But we know they don't. How has it been for you, the clinical team here, to have someone you can call or text when you need something?

**J:** It's a lot better. It's a lot better. We used to run into walls all the time with hospitals and verifying doses\(^{20}\). They can't for the life of us find out... nobody knows who's supposed to verify it. Nobody knows. Nobody wants to, nobody wants to, nobody wants to [multiple calls]. Call medical records. You do know that [this is a] continuation of care, it's not like...

**Heather:** I don't think they realized that the patient is sitting there staring at you, waiting for their medicine. And you can't give it to them until you get the dose verified.

**J:** I know. Because literally, if they've missed three days [of MOUD], and [the hospital] can't tell me that they got their 100 milligrams [of methadone], we're going to cut their dose by 30 milligrams, and now you're playing with their ability to stay clean and sober. Because the cravings could come back. Say this happens on a Friday, and we don’t have providers here, and we have to cut their dose, they may withdraw for those [weekend] days and use something else on top of it. And then we can’t get orders in until Tuesday because the provider comes in on Monday...

**Heather:** I think the BRIDGE has done a good job of educating ED physicians on what those next steps are for an OUD patient after discharge. That they will be [at your center] waiting for care, and that we can integrate simple steps into our discharge process to facilitate downstream patient care.

**J:** Right. Now the nurse or the provider, or peer from [the hospital] discharges the patient with a MAR\(^{21}\), so we at least have some idea of the medication given. It’s a lot better to have a MAR now, so when we do a urine drug screen and its positive for a benzo[diazepine], we’re not waiting hours for medical records to send us something over. It sort of... destigmatizes it. Now it’s just a normal follow-up visit.

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\(^{20}\) When a patient receiving treatment for OUD at a treatment center goes to the hospital, the treatment center must verify what medications the patient received during their visit before MOUD can be re-started. This is because in part, some patients will use opioids, and tell the treatment center that the opioids in their system came from the hospital. Conversely, hospitals rely on treatment centers to verify MOUD doses for ED patients as well.

\(^{21}\) MAR stands for medical administration record and lists the care a patient received during their time in the hospital, including all medications given.
The need to reduce stigma around OUD is well-documented (for examples, please see Meier et al 2021; Stone et al. 2021; Adams and Volkow 2020; Lefebvre et al 2020; Atkins et al 2020; Yang et al 2019). Numerous articles published within the last year alone have underscored the clear opportunity right now to reorient provider education and practices to reduce stigma around OUD (Atkins et al 2020). One of the ways the BRIDGE program continues to do this sort of reorientation around what it means to have OUD includes the use of “person-first” language in all trainings, didactic lectures, grand rounds, and literature (both physician and patient facing). Here, person first language puts the patient before the disease, and describes what the patient is experiencing instead of referring to addiction in a way that makes it appear that their use of drugs comprise their whole identity. For example, “the drug abuser in room four” becomes “the patient in room four experiencing opioid use complications.” For further examples of person-first language in addiction treatment, please see Appendix H.

The adoption of person first language increases candor between the patient and provider, coupled with the creation of a tangible care pathway, has opened the flood gates, where stigma is steadily receding into the background of an ED encounter, to disappear entirely one day. A resident physician who began their training right as we were implementing the BRIDGE pathway shares what they have learned about stigma reduction, along with how patient encounters used to go for them before the BRIDGE.

S: I feel like if you... if you can show [the patient] clearly, ‘I'm not here to judge you’. And I've learned that only takes around five seconds. It's just your attitude when you walk in [the room]. But I know going in now... it’s so different, knowing that you have some kind of tool in your toolkit to help them out. It seems like there's almost a shift in the air, that the entire interaction is [going to be] more positive. And at the same time, that opens [the patient] up to being more open with you. If you go in there, like hey, I’m gonna help you out, just got some questions. It's amazing what they'll tell you.
Heather: You joined us right as we were bringing the BRIDGE pathway online. Walk me through one of your typical patient encounters before you had the pathway.

S: Oh, you're withdrawing? That sucks. Here's some benzo[diazepines], you should probably go to [treatment]. I mean, that's all we had. That was the only available option. Treat the side effects of whatever they're withdrawing from, make sure that they're not going to die if it's a benzo[diazepine] or alcohol [withdrawal], and refer out. Here's the phone number for [treatment]. Go call case management, call social work to see if they have any other information. Maybe [the patient is] one of the lucky ones that has insurance and can go to one of the inpatient facilities. But for the most part, it's just sorry, sorry. The social worker will be by with a piece of paper. Yeah, that's pretty much it. Make sure they're stable, get the vitals normal, and get them out.

Heather: What sort of patient interactions would that [lack of treatment] lead you to have? How was your actual time with the patient?

S: Pretty poor, and [I felt that] I was leaving a lot on the table. The interactions I felt were very poor, I felt very limited in what I could offer them. Which kind of gave me [the attitude] going into the encounter a sense of just 'well, crap, what am I gonna do', you know, except for slapping a Band-Aid on the issue, and they'll be back in twelve hours, back in withdrawal. There's not a whole lot I can do. So if I was going in there, I already felt defeated before I even walked into the room.

But let's say maybe they have cellulitis at the same time. Great. Now I can admit them and get psychiatry to see them! I actually would get excited when they would have a somatic issue that needed admission, because then I knew they were gonna get some kind of assessment for their psychiatric issues, some sort of follow up. But now I feel like I actually have tools, and something in my pocket. Like here, I can offer you this. You may decline it, but at least I have something I can give to you.

This shared sense of helplessness often led to negative patient encounters, with little resolution. But the frustration over not being able to provide meaningful care day in and day out can become ingrained in the way a physician practices medicine, and not everyone was immediately sold on the BRIDGE pathways ability to mitigate the long-standing negative impacts of having nothing to offer.
Heather: When we started implementing the BRIDGE pathway, where probably for the first time in your medical practice you had a thing that you could do for patients that were using opioids, what was that like for you?

Q: So frankly, it took me a while to come around to [the BRIDGE]. Because I was living in this [headspace], trying to be empathetic and trying not to be judging, but also still frustrated that there was nothing I could do. It was hard to believe that something could finally help [OUD] patient encounters. And I was sort of taking pride in my ability to connect with these people. I was taking pride in the ability to get them to open up and talk to me. That was always sort of one of the things I thought I was able to do well, by just being totally honest and straightforward with them. But still really having nothing to give besides, ‘I'm sorry, I know this is hard’ or something like that.

Heather: Social work will be by with a piece of paper?

Q: Yeah! I mean exactly. Exactly right. So the first time... the first time it really worked [activating the pathway] it actually brought a tear to my eye. This girl who had been in twice over the last week, basically ran out of whatever her standard stuff was and had been trying anything she could get her hands on to keep from being sick. She was at her wit's end, because she was supposed to start a new job the next morning and was worried that she wasn't gonna make it, that she was gonna lose [her job]. She'd been trying so hard to keep her life from unraveling, and now it was going.

Q: My resident went in there and was like, "Oh, yeah, she overdosed on this, blah, blah, blah. We'll [observe] her for a little bit, and then we'll get her out of here. And I just suddenly said, ‘No.’ I went in there and talked to her, and actually got the whole story from her and figured it all out. We got her set up with a dose [of MOUD] which fixed her [symptoms] and then got her a bridging [prescription]. And she was... the sense of relief was palpable. It was just, it was amazing.

There were a lot of stories like this from the early days, when providers took that leap of faith to initiate OUD treatment through the BRIDGE pathway. Even with formal training, support, and infrastructure, we were still asking them to do something that their whole medical career said they weren’t responsible for doing. The confidence of physicians having a treatment tool led to an openness in the patient, which in turn fostered an increased understanding about OUD for both parties, washing away the social façade of drug seeker, someone just choosing to stay high and could just as easily chose not to; that the OUD is their fault. As physicians
explained to me, suddenly, for them, the patient morphs into a structurally vulnerable human being, sick and seeking care. The woman in the above encounter had actually been to two other ED’s in the area and had been turned away, dismissed at one for drug seeking, and dismissed at the other because they didn’t have anything to offer her but a referral to treatment that wouldn’t come in time to save her job. Here was a woman that was trying for so long to get a job, has finally found one, but she's sick, so she's going to lose it. And if that job is lost, at what point would she perhaps have gone on to use again, potentially overdosing? Q and I mulled this over, and they said “Well she was still actively using. But that wasn’t the concern that day. It was a question of stabilizing her enough to give her an opportunity to add one more building block to getting into recovery. And that was enough of a win at that point”.

Fortunately for the long-term prospects of the pathway, what the physicians termed “the wins” did not stop with the patient who kept her job. The following are other examples of success stories involving BRIDGE patients, including an impassioned email I received unexpectedly from a physician, sharing how the pathway was helping them in an unforeseen way.

**Leaving AMA**

“I have definitely had positive stories. I’ve had multiple patients with opioid use disorder, including one with bad endocarditis, who were planning to sign out AMA to avoid withdrawing but stayed because we offered MOUD and could manage their withdrawal”.
Leaving the hospital against medical advice is exceedingly common in drug using patients. Multiple patients have told me stories about their frustrations, from being stigmatized, to not receiving adequate care, or maybe even just not being able to smoke a cigarette. But the overarching reason that trumps all other reasons for leaving AMA is the abject fear of getting dope sick while admitted to the hospital.

**Respectful Treatment**

“*Probably the best story [I have] was a young kid who came in wanting help and was in withdrawal. He said he heard from a friend that [this hospital] was respectful and treated people like him kindly. He told me how he'd avoided doctors and hospitals in the past because of how poorly he had been treated. The last time I heard, he had successfully completed outpatient treatment.*”

Patients avoiding doctors and hospitals crystalized into a part of the culture among opioid users, even in the face of life threatening illness. It takes an intense level of vulnerability to seek out help for drug use or drug use complications, and when someone is treated poorly while in such a vulnerable state, it leaves a mark. And this mark is shared socially amongst other drug users; a warning to stay away from the healthcare system if you don’t want to be treated ‘like a scumbag’. This patient in particular had heard from friends who had been enrolled in the BRIDGE that it was real, and the hospital was respectful, which led him to seek care. That social, word of mouth storytelling is vital in this population, as many would not trust the hospital to provide them with care unless they had heard from someone they know that it is possible.
The Success Story

“Do you remember [patient]? Gunshot wound, and all that crap. He came in not too long ago. And he's doing amazing. Like, I could literally cry, like, whoa! He came in to say hi and thank you for saving his life. I was like...I can’t believe [it]. When does that ever happen? He got his teeth redone, he was clean, he’s been going to the gym. He's replaced all his bad habits. And all this, mid-COVID. He reached in to give me a hug, and I'm like, I don't even care [hugging him back]. I'm just so proud of you.”

Rarely do providers get the chance to see firsthand the positive impact the care they delivered had on a patient. Once a patient is discharged from treatment (especially in the ED), the provider usually does not see them again unless they come back to the ED as a patient. For this patient to make it a point to come back to let the provider know what they did for them will likely stay with this provider for the rest of their career, and positively fuel them to keep providing OUD care.

The Letter

“I wanted to send a quick note to thank you for the work you’re doing. Two patients last night [that] I saw in triage told me they specifically came to [this hospital] for help because they heard from other patients that we could help them. That our hospital was known in the community for treating people with substance use disorder kindly, that we help people like them. Another physician on the shift had one or two other patients for similar reasons as well, and we were able to [activate the BRIDGE pathway] in one sweep to get everyone taken care of. On a more personal note, I found out today that a
friend I grew up with died of an opioid overdose this weekend, leaving behind a two-year old daughter. Professionally, the BRIDGE has been a source of respite from burnout; but personally, as I grieve the loss of an old friend that I lost touch with, it's helping me make something meaningful out of the loss, even though there's no bringing them back. I really do appreciate the work you're doing.”

Eventually this sort of person-first approach to addiction treatment alters the provider’s essential framework to include a more nuanced understanding of the OUD experiences. For example, an attending physician shared with me their experiences with this framework change during a shift.

“I have seen definite changes in the patient care discussion, either directly to me, or to the resident [physician], or case manager, or social worker... really anybody involved in one of these cases. The conversation has shifted to ‘Okay, this is not judgmental, there are options, we're here to actually give them a hand’. I feel like this is, you know, step one, in [treatment] just removing the stigma around [OUD]. Now we really, like really just let them know, “Hey, we're not here to judge you, even if you're still out there [using]. I'm sure most other ER doctors are going to be very judgmental, but when you come here [to this hospital] we are different- tell your friends. Tell them we want to have a frank and open discussion and get you the care you need. I feel like I am seeing that all the time [now].”
It Doesn’t Always Come Up Roses: Pathway Breakdowns

Overall, the BRIGE pathway has been successful, but with any new process there are going to be bumps in the road. There were times where there wasn’t enough dissemination about pathway availability to new staff (social workers, case managers, nursing, physician assistants) and patients fell through the cracks because the clinical team did not know to offer the treatment. There were times that no matter how much information was disseminated, there were physicians who chose not to utilize the pathway for their own reasons. In the beginning, it was not considered that a patient may use the heroin they brought to the hospital with them while waiting on buprenorphine orders to be placed, which would then throw them into acute withdrawal during the ED encounter. Perhaps the most salient example of a breakdown in care was one of the first patients enrolled. A young man came in with acute withdrawal symptoms, and the clinical pathway instructions were to give 8 milligrams of buprenorphine. So that is exactly what the physician did.

This particular patient, however, had an extremely high tolerance due to using around 10-15 times a day so 8 milligrams was not enough to stabilize his withdrawal symptoms. About seven hours after his discharge, paramedics found him unresponsive behind a McDonald’s dumpster. A trauma alert was called, and while everything was done to save him, he ended up passing away of cardiac arrest secondary to opioid overdose. I am haunted by this, and wonder if the buprenorphine dose had just been increased, could that have been avoided? This event resulted in a change to the pathway with specific titration instructions for high tolerance patients. The pathway isn’t a magic bullet, and sometimes things don’t go the way they should.
But by and large, building out the clinical treatment infrastructure for OUD patients in the ED has potentially resulted in many lives saved.

‘I heard you treat people like me’: Patients Actively Seeking Care

“The relationship between addiction, self and identity should be informed by participants' own accounts of their experiences of addictive behavior problems... self and identity issues may well be crucial to our understanding of the experiences of addiction and recovery” (Larkin and Griffiths 2009: 281).

The previous section reflected on how the BRIDGE pathway acted as a catalyst to alter the experiential frameworks of treatment providers. With this section I want to examine the ways in which patients navigate the relationship between what it means to be normal[ized], and how their experiences have changed since gaining access to care through the BRIDGE.

Heather: Were you surprised to see that we had a MOUD team?

Paul: I was blown [away]. Oh yes, I was blown [away]. Because I was just, it wasn’t that long ago that I was there. And they were giving me liquid Oxycontin in a little cup. It was nowhere near enough. I mean, it was like 10 milligrams or something. I could have done 100 of those [cups] and been fine. And they’re telling me "Well it’s not our job to get you high." I said I’m not trying to be [high] I’m just trying to be [normal]. I mean touch my back. Feel me, I'm soaked, I'm freezing, I’m sick you know? Yeah. So But yeah, I was very happy about [the BRIDGE pathway].

This concept of normality, of OUD being normalized in the ED, kept cropping up in conversation after conversation. Either patients returning to some state of self-ascribed normality after gaining access to care, or overall just regaining the ability to feel normal in spite of OUD. This concept of normality seemed so novel to patients because they accepted the fixed state of addiction they had been exposed to by society and the healthcare system and were unaware
that it would ever be possible to return to what they considered their ‘normal’ pre-drug use self again.

**Heather:** If I can ask you, when you first came to [my hospital], all those years ago. What was it like for you? Was the care you received this last time different than other times you'd been to the hospital?

**Amelia:** Very much so, yeah. Yeah, a lot different. I was just looked at like a junkie [by] most of the staff. Working in a hospital before, and being on both sides of it, [that] was really disheartening. It was. I mean, it was... it's hard to describe. It's not something that you would expect. There was no compassion. You're supposed to have compassion for patients, no matter what situation they're in, no matter what happens to them. But then you put me in a completely different light [because of opioid use] when I look just like everyone else. Because I've been there before [as a nurse]. And it's like... to be on both sides of the coin [shakes head] how could you treat people like that?

It's tough. Like you go from this legitimate person, right? To this, delegitimate person who is... you're not deserving of care. You don't have a real issue. You shouldn't be here. Why don't you just stop? Like all of those, like narratives we have. Right? [right]. So...yeah, that day, when we checked in, they were like, "Oh, we have this program you guys can get on. I'm like... I'm like, wait a minute. They're actually showing interest. What are you talking about? You pinch yourself. Yeah.

**Heather:** Did you feel like you were humanized? [yes] That you received care [yes] like you were just a normal patient?

**Amelia:** I did. Yeah. But it’s not just in the hospital, either. It [being in the BRIDGE] definitely assisted me here at Shady Vale, getting into the MOUD program [here] has definitely [helped]. I mean, in two months since I've been residential, I've put on 30 pounds. It's insane.

**Heather:** You look very healthy.

**Amelia:** Thank you. I've been working on myself, doing what I can in the gym with my neck and back, trying to... just trying to get back to a normal person, a normal life.

Darlene, who came in for an abscess and was also enrolled in the BRIDGE, comments on her yearning for normality in spite of the social brand placed upon her for having OUD. Again, you
see a notion of fixity, that she will ‘always be an addict’ but still regards herself as deserving of normalcy in care.

“This is an awesome thing [you’re doing]. You know, helping with the abscesses, and [helping us] get health care... that’s an awesome thing. I’m glad somebody did [this]. You know, I mean we’re addicts, we’re always going to be addicts, but at least now we can get some help. I could never get help before. One time I woke up in the middle of the night in the hospital bed with two nurses lifting my shirt up and pulling my pants down. I said, ‘Hey! What are you doing?’ Looking for [track] marks, they said. [she shakes her head] You know what, it’s an addiction. We’re all not proud of it. But everyone deserves to feel normal.”

Pauline, who also struggles with recurrent abscesses, remarked that any time she would tell the doctors in the ED that she got an abscess from injecting, ‘their whole demeanor, everything changes, everything changes.’ After the BRIDGE pathway was implemented, Pauline was able to feel like a ‘normal’ patient who received respectful, dignified treatment during their ED encounter. When asked about how she felt about the care she was receiving during this hospital visit, she exclaims:

“Oh, these people now? I love them, they’re great. They don’t, they don’t demean me in any kinda way. They’re always helpful. They ask me anything, about what I need, you know, they’re great. And that’s different from anywhere. You don’t find people like that, right? At least I hadn’t. These are people that don’t judge you, you know. I know they
don’t... I’m sure they don’t. It feels like [they’re one of us]. It just feels like I’m here for a normal thing.”

This disruption of fixity toward a familiar sense of “normalcy” in the words of participants, was present not only in the ED but also carried through once a patient was in community based treatment as well. During a visit to one of the study’s treatment centers, Tanika, a recent BRIDGE enrollee, stops me in the hall to let me know how normal she feels now.

“I just wanted to thank you. It’s like, once you get into treatment, and you start to sort of feel safe, you’re able to manage it [OUD] a little bit more every day, you feel a bit more normal every day. I don’t know what I would’ve done though, without you [all] in the hospital. Because just asking someone to manage this [OUD] without any type of help up front... I don’t think it’s realistic. Because it’s still... it’s still the people, places, and things. Like, being in the hospital didn’t remove me from any of my triggers. [And] when I first started taking opiates [for pain], the doctor never told me I’d get addicted, none of that, you know, and before I knew it I was addicted. But I’m getting it [my life] back, one day at a time [now].”

Then Tanika shared with me that her teenage daughter recently started injecting heroin—My daughter. She, she [sighs] she just started, so I’m hoping, you know... it’s hard. Can you help her? So we make plans for her to come to the ED the next day.

Another area of pressure released for patients after BRIDGE implementation was around the concepts of truth and trustworthiness. Suddenly they aren’t just a drug seeker
anymore, and the truth coalescences into something ok to be uttered to the physician during an ED encounter, instead of something to adamantly hide.

“Yeah, that was something I never understood. You know, trying to see if I’m telling the truth. Telling me I’m lying. Asking if they should go with my story. I’ll tell you anything you want to know... Hey, I’m in withdrawal. This is what it feels like, this is what I’ll do if you discharge me [without care].”

I asked one patient at the treatment center why they felt that it was so much easier to be truthful with providers now.

“Every time I’ve come here I’ve been very [taken care of]. It’s been wonderful. Anisa. I remember her from the very beginning. A couple other BRIDGE people I’ve gotten to known here for a while. And there’s a couple other ones that I don’t see [anymore], I haven’t seen in a while, since the beginning. But I mean, that first time, I couldn’t believe it when Anisa started talking to me. She was very respectful, friendly. You know, over what is it? Above and beyond type? Excellent. Yeah. That really changed things for me. [now] I like coming here [for treatment] now”.

The person this patient is referring to, Anisa, is one of our Peer recovery specialists. A Peer recovery specialist is someone who is in recovery themselves, that has received additional training and education, who then works in healthcare spaces to link patients with OUD (and other use disorders) to care.
Modeling Recovery: Peer Specialists in the ED

In the ED, Peer recovery specialists act as BRIDGE between providers and patients, helping to facilitate an otherwise [potentially] contentious exchange. Peers model recovery to providers during every shift just by existing in the space, which gives providers a 3D representation of the fact that successful recovery is possible. Peers personify the reality that everyone made it to the path of substance use for a reason, but people are more than their addiction. Peers also model recovery to the patient, which gives them hope that they are more than their addiction, and that recovery is possible. Most of the formal knowledge patients acquire throughout their addiction trajectory from various places, including drug courts, addiction counselors, or 12-step programs, asserts that they are an addict, they will always be an addict, that they will have to struggle the rest of their lives against the ravages and temptations of addiction. This creates a sort of fixed trajectory for patients, a resignation that somewhere along the way they have malfunctioned compared to their peers. That they are less than, now that they are “just an addict.” Peers work to unmoor that fixed trajectory mindset by demonstrating that patients are not consigned to “being an addict” for the rest of their life, that treatment and recovery are possible.

A program director of Four Pines and I sat down one windy Tuesday afternoon to discuss the BRIDGE, and I asked them how things have been different since peers were integrated into ED care for OUD patients.

Heather: How many patients do you think Four Pines saw from the hospital before the BRIDGE?

V: Prior to the advent of the BRIDGE, the process of getting persons from the ED to Four Pines required a nurse to nurse call to verify bed availability, and to determine if the patient met the admission criteria. This was a highly cumbersome process that had
several points of failure, not the least of which started with the intake nurse answering the phone, if he or she did. The result was that only one or two persons were transferred each month.

Heather: That sounds very cumbersome.

V: With the advent of the BRIDGE, the linkage between the ED and here immediately improved. Rather than a nurse to nurse call, the Peer, who is a Four Pines employee, was able to assess the appropriateness of the placement, ensure that a bed was available, and effect the transfer. But this was only the start. Having a Peer in the ED reminded physicians, nurses, social workers, and case managers that there were outside resources available to persons struggling with substance use disorder. Having a Peer who circulated throughout the ED and who was available to meet with both staff and ED patients also meant that physicians and other medical staff had someone to actually link the patient to services and treatment.

Heather: Yes, that has been wildly helpful from the treatment team side. How do you think it has changed for patients?

V: From the patient perspective, having a nonmedical person who has also struggled with substance use helps to ease their shame and embarrassment. Participant’s report feeling that the Peer is someone they can relate to and therefore, are more willing to trust. Rather than being “sent” to detox or treatment, patients are engaged in their own recovery planning and, thus, are more likely to follow through or follow up on the Peer’s recommendation.

Heather: I also think it has really helped patients navigate the often difficult process of seeking any sort of behavioral health care.

V: I agree. The Peer has been instrumental in following up on referrals, whether it be to the inpatient unit, MOUD unit, another program, or another treatment option altogether. Since a lack of human and social connection is often a hallmark of persons struggling with chronic substance use, most persons, even if they desperately want recovery, are at a loss. The Peer is not only a BRIDGE between the hospital and various treatment options, he or she is a BRIDGE back to the community. By checking in on the patient both at the hospital and post placement, the Peer demonstrates authentic concern, which is a requirement if trust is to be restored and if relationships, therapeutic or otherwise, are to be re-established.

V: I share these insights based on my observations of Anise, particularly when she is here visiting patients [from the ED]. There appears to be an almost instantaneous rapport with the patients. It’s obvious that they are pleased to see her and honored that she comes to visit them. Even though they may not be at a stage of change yet to enter into treatment, her presence, and their reaction to her suggest that they are, at
the very least, one step closer to taking back control of their lives. Though perhaps, most telling of the effectiveness of the Peer in the ED, is the significant increase in persons being referred each month.

V shared with me that if they had 3 or 4 referrals a month prior to the creation of a formal BRIDGE pathway, that was a lot. Since the BRIDGE begin, they have had as many as 40 referrals a month, which is an astounding difference. I believe that, along with Peer integration, one of the key reasons the BRIDGE functions so efficiently is due to its composition mirroring other clinical pathways for care. This familiarity eases providers into the new process during busy ED shifts, when it is all too easy to make a mistake, and that familiarity and comfort with the way ‘things have always been done’ equals patient safety.

If You Build It, They Will Use It (sort of)

If you flip through nearly any emergency medicine patient care manual, the trainings are organized into clinical pathways (see Figure 5.1 for example).

![Figure 5.1: Table of Contents from Emergency Medicine Training Manual (EBMedicine.net, 2021).](image)
Specific care pathways for assorted disease states being utilized in the ED is not a new concept. So utilizing this pre-existing framework when building the BRIDGE pathway made it easier for physicians to adopt this new process into their clinical practice as it did not look any different from what they were already doing. One physician remarks on this:

“We are herdable. Like cats, maybe, [laughter] but we are somewhat herdable. If you say, this is the parameter, and this is, you know, what needs to happen, most of us will comply. We may whine about it a lot. But we’ll probably do it. You know, if you say this is the pathway, right? For example, if there’s a sepsis bundle, or pathway, or whatever you want to call it, we understand that. And we’re going to do it [for a variety of reasons]. One, I’m going to get paid less if I don’t. Two, they [the administration] are going to think I’m terrible. Or without [doing] it I’m going to get sued. So you know, I don’t think it’s necessarily hard to steer us [if it’s something we recognize]. You’ll get pushback, you’ll get heels dug in, you get people whining. But at the end of the day, if you set up [like this] and say this is it, [this is the pathway] most of us will do it.” (Personal Communication, 2020)

Figure 5.2 an example of a clinical pathway for patients that may have had a liver injury, next to an earlier version of the clinical pathway for MOUD.
Figure S.2: Clinical Care Pathway for Hepatic Injury Compared to Early Version of BRIDGE Pathway
The arrows mark decision points in both pathways, with a clear starting place. Essentially a step-by-step roadmap for delivering patient care for a particular issue. Later iterations of the clinical workflow more closely resembled the workflow on the left. You will quickly discover, however, that it is not enough to just make something mirror what already exists and hope whatever you’ve made will be successful. To have a truly successful clinical treatment pathway, that is consistently utilized as envisioned by the creator, it must be created with physician input. The No. 1 rule, experts say, is “to follow when developing critical pathways for your practice is to involve your physicians every step of the way” (Boguszewski 2000: 1). The expert in question here, an executive leader of a healthcare system, intones “For the process to work, it has to be led by a physician practitioner. The success [of the pathway] depends on physicians having buy-in. If they feel they have been left out of the process, they may not follow it” (Boguszewski 2000:2). When drafting each version of the clinical treatment pathway for the BRIDGE, physician stakeholders had input into every change or edit. Further, I partnered with a resident physician in the building of this pathway, and we were both mentored by an attending physician with a leadership role within the ED.

The resident physicians cared for patients, as well as assisting in the creation of trainings and dissemination crafted for maximum retention and understanding based on pre-existing emergency medicine training. For my part, I secured the ongoing engagement of community treatment partners, handled administrative issues, created, and gave lectures and trainings, worked closely with social work, case management, psychiatry, pharmacy (any department that would play a role in this pathway), conferred with other addiction professionals to ensure our treatments aligned with the current standards of care, and (most importantly) had near-
constant communication with OUD patients (the other key stakeholders in this) to make sure what we were building was what they needed. So, a lot of moving parts, but all critically important. It is important to secure all of these moving parts, as a patient’s typical pathway thorough the ED interacts with each of these pieces.

When a patient first arrives, they are interacting with administrative components to get registered and share what health issues they are experiencing. The administrative component is also important to make sure things are billed correctly, patient information is current in the electronic health record (EHR), etc. Patients with co-occurring mental health issues may need a psychiatry consult, social work/case management is an important component for assisting with structural issues like transportation, and downstream treatment partners are critical to the creation of a pathway that bridges the ED visit on to recovery. Below, physicians weigh in on other key considerations in creating a successful treatment pathway, as well as how this particular pathway has changed their clinical practice.

The Bottom Dollar

“I hate to say it but connect [it] to the bottom dollar, if you really want to get doctors to listen. Talk about [things like] ‘your patient satisfaction will go up, it’ll improve your Press Ganey’s, it’ll improve your reimbursement, it’s going to increase your throughput times, it’s gonna increase RVU\(^\text{22}\), decrease [your] length of stay, decrease [your] admissions. Things like that. But really, just in in general, I think what this specific

\(^{22}\text{RVU stands for relative value unit, which is currently used by Medicare to determine the amount of reimbursement for providers.}\)
pathway does is connect [it] back to the human aspect of it, you know, just because that's so often lost. I was thinking about that the other day that how, you know, especially right now with you know, 75 [patients] in the lobby, and the ERs overrun, it's no longer Mrs. Smith in bed two needs her antibiotics. It's the toe pain [over here] or, you know, the chest pain over there...we dehumanize so much."

In this instance, the advice was to get your foot in the door by connecting use of the pathway to a physician’s wallet—essentially saying that if you utilize this care pathway your metrics for reimbursement will improve. The pocketbook is a good initial approach to rely on, but once the pathway really begins to work for the physician though, cost savings are realized as well as reimbursement gains. This is a highly effective negotiating point, as saving money is also a huge focus of healthcare systems.

Return on Investment

“Even if the program, [even if] one out of every ten people get helped out, they [the hospital] are still gonna save so much time and money for the entire system. One out of every ten people, that it would be worth it. If we start something small like that and build it up to then show a return on investment of one or two patients. Like my God, that would be huge. If we stopped one case of uninsured endocarditis, that’s like $60,000 for the healthcare system. Or what is the average cost of a liver transplant over the course of liver failure, isn’t it like 1.5 million? For Hep C, right. Every new HIV infection is $400,000. So yeah, I guess the pocketbook is a good strategy.”
This ‘pocketbook strategy’ is a good to use especially when working with hospital administration or community providers, who want to know how this new care you are proposing will help decrease the bottom line. Focusing on finances won’t solely be enough to get a new care pathway implemented, however. Physicians and patients both need to buy in to the process, e.g., to believe that it is possible, will work, and is worthwhile.

**Buy In**

“I would say the biggest thing is you just need buy in from upstream and downstream people, but I think you know that. So you would need buy in from physicians that this is a process that adds value. And then I think even before you approach the physicians, you would need buy in [from] the downstream people of where these patients are going to go. And you need buy in from the community, and the people [that would] provide funding [who see the value] and [that it’s] worthwhile. And even that... they believe it’s a patient population worth treating, as awful as it sounds. That’s probably the first conversation you have to have, is that these people matter.”

Value added is an important concept in medicine. Whenever a new care pathway, initiative, program, etc. is considered in the context of patient care, it must be something that adds value to a patient's care and the patient experience. Below, physicians reflect on how their practice of medicine has changed since implementing the BRIDGE pathway, including normalizing drug use, increasing empathy, and avoiding burnout.
Seeing Everyone as the Same

I think really [having the BRIDGE], for me anyway, [has] kind of lumped these other substances in the same category as alcohol. Where I see [now] how powerless people are to make those changes or deal with that [drug use] for oh so many reasons. I think [that is] the biggest thing for me. In a way, illicit drugs, right, have a different connotation to them than say, alcohol, which is socially accepted. So when somebody has alcoholism, it’s sad that their socially accepted outlet has become something that they couldn’t control [and now they’ve lost that outlet]. Whereas if somebody has an illicit drug issue, you know, it’s not a sad thing. It’s, they’re a weak or terrible person kind of thing. You know what I mean? So, whether you call that stigmatization, or depending upon what values or beliefs were instilled in you as a younger person, you might see a heroin user very different than you would see somebody who drinks a little too much. Or you might see a cocaine user differently than somebody who, you know, drinks way too much, right? I mean, why would you see those people as different, right? Except for the construct of what is socially acceptable or not. So I think the biggest thing for me was to break down that barrier and see them all through the same lens.”

This was a remarkable and unexpected revelation to me. I knew that drug users are socially stratified amongst themselves (for example, it’s more acceptable to snort cocaine than smoke crack, though it is the same substance with a different processing method) but I never formally considered the possibility of a similar stratification among treatment providers in an ED setting. To hear that sometimes providers would go easier on someone who uses alcohol versus
someone who uses heroin closed a loop for me in that the same social processes and quantifications of drug users that happen amongst themselves also happens organically in treatment spaces because we all come from a similar social structure. Here, the BRIDGE essentially helped level the playing field for substance users, so the treatment became the same regardless of substance used. This leveling then led to a shift in attitudes and perceptions around substance use by providers. Pre-intervention, 88% (n=8) of physicians regarded OUD patients as drug seeking, for example, and 100% of patients reported feeling like they were labeled as drug seeking which greatly reduced or stalled any care they received during the ED visit. Post-intervention, 100% (n=8) of physicians and patients interviewed reported improved patient care and a change in attitude about addiction. One way this increase in patient care was possible was due to the BRIDGE removing the relevance of ‘drug seeking.’ There was now a formalized treatment pathway, with medication available to give the patient, which would resolve withdrawal symptoms in around thirty minutes. Gone were the days of sitting in a hospital bed, writhing in acute withdrawal, to only be discharged 10-12 hours later no better off than when they came into the ED.

Changing attitudes

“I definitely see attitudes changing. I mean, alcohol is legal and socially acceptable. So to [doctors], there was a gap between someone who may just have ‘had a few too many’, and an IV heroin user who’s using illicit drugs off the street. There was a dichotomy in [our] mind of those two individuals, even though it’s both substance use disorder. But all substances are the same chronic relapsing disease, right? And it’s maybe because some
of it might hit home... like we've all had one or a few too many drinks, and we don't want to feel like we're [addicted]. I mean, who hasn't been out there and been watching a football game and had five, or six, or a 12-pack [of beer]? You want to feel like [that’s okay]. ‘I've been in the same boat as this person drinking’, so I want to feel good about myself. I'm making that mental gap. But now that’s changing.”

In addition to saving money and shifting perceptions, the BRIDGE has also had the unintended consequence of helping providers avoid burnout when it comes to OUD patients. According to TEAMHealth, a well-known physician contracting service, burnout is-

“…a syndrome characterized by emotional exhaustion and loss of enthusiasm for work, feelings of cynicism or depersonalization, and a low sense of personal accomplishment. Physicians on the front-line of care access—family practitioners, general internists, and emergency physicians—are at the greatest risk and experience the highest levels of burnout (TEAMHealth 2022)”.

This syndrome can have serious consequences for a provider’s health and a patient’s care. During interviews, 100% (n=8) of physicians I spoke to post-intervention revealed that the pathway had buffered them against burnout in some way.

Avoiding burnout

“The BRIDGE pathway, I think, mitigates [burnout]. That phenomena of having a patient that comes with a structural illness that historically I had no care to offer them. I think that circumvents burnout in physicians. If we could implement something like the
BRIDGE pathway that’s been so successful to even more simple disease processes like chest pain, or gastritis, or things that I see all the time [that] patients come back to me time after time [for], but it’s recurring. A good example would be someone with a concerning migraine. They’re getting migraines all the time, and they’re debilitating. And I give them follow up for neurologists. And I know full well that if they call that phone number, there’s not going to be an appointment for six months, and they’re not gonna have any way of transporting themselves to go to it. And that... that really drags on me during a shift. To feel like I’m being duplicitous in a way, saying this is what our healthcare system says I should do for you. This is the opportunities I have, these are the follow up appointments you’re supposed to go to, and I know full well, it’s not going to happen. So having the BRIDGE, where I have more confidence that if I enact the pathway, that there’s some follow through, and some people on the other end that actually implement the care and get them to the final destination. If I could have that in other aspects of my career, I’d absolutely feel better about my job.”

A major cause of burnout that I have personally witnessed through my time at the hospital is seeing the same patients over and over, and not having anything to do for them. These patients often have serious structural inequalities as well, that prevent them from following the recommended care providers offer. And while these patient interactions may still be challenging—physicians can’t write a prescription for an apartment or fill someone’s fridge with food—understanding the structures in patients’ lives that prevent them from following care recommendations has helped increase overall empathy towards OUD patients. Pre-
intervention, 100% (n=30) of interviews reported some sort of treatment frustration around OUD-related ED visits. Much of this frustration is due to structural issues that are not able to be resolved during a short clinical encounter. Post-intervention, 75% (n=8) of physicians and 80% (n=10) of patients reported a greater understanding of structure and how structural inequalities affect substance use disorder. From the physician side, this increased understanding of structure resulted in increased patience and empathy during the clinical encounter, and for patients, it resulted in a greater understanding of exactly what care is available in an emergent setting versus an outpatient setting, often diffusing patient frustration due to unrealistic treatment expectations.

**Recognizing structure**

“Um, I think I just have more empathy now for people that are kind of struggling in general. I think a lot of the patients I see are very challenged with the environment they’re given. I run into it a lot, basically like systems processes…like how do you take care of yourself if you have no transportation? Just very root fundamental things like that. So understanding systemically, like the structural inequalities that prevent someone from [being healthy]. And [now] I view substance use as just an extension of that. We had a patient that was really well known for having cocaine cardiomyopathy, he had a terrible ejection fraction, he would come in for chest pain, every two days, his troponins were always elevated. He was non-compliant with medication and would be discharged every two days to go home and use cocaine again. He eventually passed away, as the morbidity and mortality of someone with an EF of 10% is low, especially if they’re non-
compliant, and leave AMA. But that said, it’s really easy to have empathy with the guy [now]. Because if he did cocaine, he was self-treating, and could walk to the grocery store. It’s… it’s just weird. I view substance use [now] as just, kind of an extension of a failure of systems. I mean, if you look at smoking and drug use, and schizophrenia, it’s the treatment of the illness, like nicotine helps people with schizophrenia to calm themselves.”

During my time at the hospital, I always found that I could get to a good place quicker regarding the complications of OUD with someone who had lived experiences, versus someone who didn’t. And because not everyone is going to have these experiences, the BRIDGE has helped contextualize OUD for physicians who did not come into this job with any personal lived experiences around substance use share a sense of empathy about OUD complications. Pre-intervention, nearly 80% (n=15) of providers reported mistrust towards patients with substance use issues, and over 95% (n=29) of patients reported a mistrust of physicians and the healthcare system, and a belief that they would not receive the care they need. Post-intervention, 94% (n=29) of providers reported increased empathy for this population, and an increase in the ability to trust patients (or at the very least whether or not a patient was lying no longer factored into care provided). In patients, 60% (n=29) of patients actually reported an increase in empathy for physicians, and a greater trust in the healthcare system to provide them the care they need.
Closing the empathy gap

“I think the BRIDGE helps doctors who don’t have any personal experience [with addiction] be empathetic. Because even if they don’t really understand, they still have a thing that they do, and a clinical protocol. I think [this] is for a couple reasons. Number one is, once you see a success story, you are more likely to do that again, because fundamentally, even the most crotchety bastard in medicine still wants to be a good guy, like you do want to help out. So if you saw a success, that would maybe light a fire under you. Definitely. And I would argue that maybe these doctors, they’re not so much just unaccepting of [OUD] but maybe they’ve been burned so many times. I’ll tell you straight up, there’s one guy who’s coming into [the hospital] a lot. And he wasn’t able to go to Four Pines because of COVID. And every time he comes in, it’s always some reason he couldn’t get his methadone, you know exactly who I’m talking about right now. [yes] [laughter] I’ve seen him multiple times the past week, and even I’m at the point [now] wondering... I’m trying to be a champion of medication for opioid disorder, and I’m like, ‘Oh, my God, man, you’re annoying the hell out of me!’ You know what you’re supposed to do? Why aren’t you doing it? Like you’ve agreed to do this? But now, I can take a step back, take a deep breath, and say ok let’s do this again.

This reset mindset that happens for providers, even with really challenging patients, is lubricated by the ‘small wins’ they see happen with the BRIDGE pathway. The pathway is designed for providers to get updates on what has happened to the patients—Peers regularly update the ED physicians on downstream outcomes. This sort of frequent updating goes a long
way to mitigating the mental and emotional exhaustion that can come from caring for patients with addiction who are experiencing challenging social and healthcare issues.

Small Wins

With all the stress [of treating OUD patients] I really do think that seeing a win would go a long way just help kind of alleviate that emotional exhaustion. Like, you know, they're not gonna all be wins, this isn't some silver bullet. This is a long term project that shows a lot of promise. And this still isn't a 100% success rate, nothing in medicine is 100%. So, you know, we're still gonna have patients that we try our hardest on, and maybe they come in overdosed, that's gonna happen. But if we just get one or two wins versus like, in the past, where one out of every 100 might be successful. If this is three or four. That's a huge, huge increase.”

The above stories and more that ED providers have shared with me illustrate how the BRIDGE functions on multiple levels for providers, including increasing reimbursement metrics, mitigating provider burnout, uncovering the insidious effects of structural inequality on equal access to healthcare outside of an ED setting, and increasing empathy for all drug using patients. Even with all of these positive increases, there was still resistance to using the pathway by some providers. Realistically, with something as polarizing as heroin use, you just may not be able to get to a place where everyone voluntarily changes the way they have always practiced medicine to accommodate OUD patients. For these final holdouts, you may need
another mechanism; for us, it was the BRIDGE becoming official hospital policy because of a sentinel event.

**Sentinel Events and Hospital Policy Change**

A sentinel event is "any unanticipated event in a healthcare setting that results in death or serious physical or psychological injury to a patient, not related to the natural course of the patient's illness" (Press-Ganey 2022). We had one such event happen at [the hospital] that resulted in the BRIDGE pathway being written into official hospital policy, which must be offered as a standard of care to any appropriate patient. One Friday night, a young woman, we’ll call her Jessica, was brought into the ED by a police officer. Jessica had been found unconscious at a bus stop and became belligerent and combative when approached by the officer. Believing her to be a harm to herself or others, the officer brought Jessica to the ED under an LEO (law enforcement officer) Marchman. During the encounter, the physician found an underlying health issue that Jessica would need to be admitted for and placed the admission orders. The officer was called away, and for unknown reasons, the information that Jessica was being admitted as a Marchman patient for suspected OUD slipped through the cracks. Due to an unexpected gap in staff coverage for the MOUD team, the BRIDGE pathway wasn’t initiated in the ED either. The following excerpt is drawn from my fieldnotes.

*Things get a bit hazy after this, but at some point between the hours of 9pm when Jessica was admitted and 8am the next morning, she had woken up in her hospital bed in*

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23 The Hal S. Marchman Alcohol and Other Drug Services Act of 1993, or more commonly referred to as the Marchman Act, provides for emergency assistance and temporary detention for individuals requiring substance abuse evaluation and treatment in the state of Florida.
withdrawal. Jessica was caught between a rock and a hard place here—she was probably scared of getting sicker and also scared to not get the treatment for her admitting issue. Couple this with the historical stigma that drug users are used to enduring in the healthcare setting, and she probably did not feel that she could let her nurse know she was sick either. At this point, Jessica made the decision to snort a bit of heroin she had in her purse. Unbeknownst to her, this heroin was laced with fentanyl, a super powerful synthetic opioid, which is probably why she was found passed out in public in the first place. Jessica ended up overdosing, which scared the life out of her floor treatment team (who was not used to dealing with an acute emergency such as this). Fortunately she was able to be stabilized and continue her care (with a referral to the BRIDGE), but at this point the hospital wanted answers for how this could have happened.

A root cause analysis (RCA) event was triggered by the risk management and patient safety departments for Jessica’s visit. Multiple people from all over the hospital participated in this RCA (myself included) to discover how, if we had a program specifically for this, did this happen? Realistically, it was just a perfect example of the swiss cheese model\(^{24}\). We had a staff member call out that night from the MOUD team. The social worker on shift in the ED was a pool worker (not from the ED) and did not know about the BRIDGE pathway, the details that Jessica initially came in as a legal hold were not communicated to the floor because the

\(^{24}\) With a swiss cheese model, a series of barriers are in place to prevent hazards from causing harm to patients. The presence of holes in one of the slices does not normally lead to a bad outcome; but when by chance all holes are aligned, the hazard reaches the patient and causes harm (Perenger 2005).
Marchman was rescinded\textsuperscript{25} before she left the ED, and ultimately, she most likely didn’t feel comfortable or trust that the floor team would help her withdrawal and decided to self-medicate. The results of the RCA investigation was (among other things) to write the BRIDGE into official hospital policy. This treatment was to become the standard of care, offered to any patient that displayed a need for it, and communicated to all service lines throughout the hospital. What a surreal moment this was for me, though I hated it had to happen in the way that it did. I was recounting this story to one physician, who said “well yeah, it was a sentinel event.”

“\textit{What do people say? Never let a good crisis go to waste. It was a sentinel event. So you’ve built this thing, you spent years doing it. And now we have something we can point to that says we failed. And this could have prevented the failure. So now we’re all gonna do it. It was really helpful to have that infrastructure already in place. So before it would have been the same thing, right, like an understanding of a problem without a solution to add more frustration. Unfortunate that something like this had to happen but great that its now policy.”}

Initially, it was a bit discouraging to know I had something that works, and I’d seen it work over and over again, and it wasn’t until the system failed this patient that the BRIDGE became policy. After the above conversation, and a bit more personal research on sentinel events, I eventually came to understand that this is just how it works right now in healthcare. It is hard to change

\textsuperscript{25} If the patient calms down during the ED encounter, and remains alert and oriented, the physician can rescind (cancel) a legal hold if they feel it is no longer warranted (the patient is no longer a harm to themselves or others).
anything unless you can point to a specific area that is broken. Much like an IT issue, the problem must be demonstrated before a solution can be crafted. So while I lament the situation Jessica found herself in during her hospital admission, I understand that something like this was a necessary step to hardwiring the BRIDGE into a standard of care treatment.

“Hardwiring” the Process

I would like to close this chapter where we began; contemplating what it means to physicians to hardwire a process. According to the Robert Wood Johnson Foundation, there are four major steps involved in successfully “hardwiring change,” which essentially means implementing changes as a part of any institutional culture so they become “standard process:”

1) Start with a change that will be easy to hardwire and is readily accepted by the staff; 2) Understand what long-term practices have been in place and make a case for how the change will be beneficial; 3) Identify upfront investments necessary to implement change; and 4) Obtain buy-in from hospital leadership and unit managers to make the necessary changes to implement a new change (RWJF 2021). Essentially, true change requires “a commitment to incremental, sequential changes inspired by ideas generated by the staff closest to the work” (RWJF 2021). Studer Group's definition of hardwired in emergency medicine is "the process by which an organization, department, team or individual integrates a behavior or action into the daily operations to ensure it becomes a well-executed habit” (Shupe 2013: 364)." A successfully hardwired change occurs when a behavior is seen at least 90% of the time.

The following are various thoughts offered by physicians about when they knew that the process had become hardwired (a habit) for them.
Out of sight, out of mind

“I think there are two aspects of it [that] really kind of stand out to me. One, it’s that it’s easy. If I identify something, you guys have largely taken a lot of the work out of it for me. So I don’t really have any barrier to implementing it. It’s nice that if I see someone, I can identify it [OUD]. A lot of what we do, and what we talk about a lot, is cognitive offloading. You see a problem, you treat it, and then you move on to the next patient. You guys have done a great job making it exactly that simple. I can identify a potential candidate, I can put in the order, make a phone call, and then it’s largely independent of me. I can move on, and it doesn’t impact my patient care. And it doesn’t require a large amount of cognitive burden for me to continue to implement. The second aspect is that it’s, career and emotionally satisfying and gratifying to be able to actually offer something. A huge portion of this job [being an ED doctor], I see people even outside of addiction, where I evaluate them, and I have nothing to offer. Nothing to give. And even when I do have something to offer and give, I know it’s not likely to be implemented. So it’s nice to have something that I can actually give to them [that works].”

The fast-paced nature of an ED environment makes cognitive offloading critical for providers, particularly for attending physicians who are supervising a shift with many demands on their attention. I have been standing in the ED speaking to a physician many times about a patient or some work-related aspect, and I would be interrupted about every 30-45 seconds. Residents asking questions, EKG’s that need to be interpreted and signed off on, nurses verifying medication orders, social workers asking for patient clearance, consulting services waiting to
discuss their findings... the list is endless. So expecting a provider to implement a difficult process that isn’t familiar to what they already do during a busy shift has little chance of success. Something that is familiar, however, and easy has a greater chance of becoming reflexive (a habit).

**Reflexive Infrastructure**

“It [has] sort of become a lot more reflexive for lots of people. And maybe even some people that [didn’t agree with the pathway]... and I think there’s still some that haven’t bought in. But it's more reflexive and easier. And I think the infrastructure, staff, trainings that you’ve put into place, it's just made it easier. So, for example, before I would spend a half an hour with [an OUD patient] to make a breakthrough. Whereas now, I can just be like, ‘Hey, can you go talk to that person?’ And then somebody [a Peer] who's probably a lot better at it than me gets [the patient there] and does [the enrollment] and then I can just support it with whatever is needed medically. So that is huge, given you know, sort of what we're up against in the ER right now in terms of volume and resource constraints, and all that kind of stuff. So I guess for lack of a better word, it's hardwired now.”

The volume and resource constraints referred to here are due to COVID-19, which has made providing care for multiple issues more difficult. In a time where the ED is a much more turbulent place due to high patient volume, low resources, nursing shortages, and more, care for OUD patients has largely been uninterrupted due to the infrastructure put in place to
support both providers and patients. This sort of structural support can also lead to a sense of empowerment, that works to mitigate the learned helplessness often seen when caring for patients with addiction. Pre-intervention, 86% (n=8) of physicians reported receiving little to no formal training on addiction in medical school or residency. Post-intervention, 100% (n=8) of physicians reported increased treatment comfort and increased feelings of empowerment to treat this population, while 80% (n=10) of patients reported increased feelings of empowerment during the treatment encounter. Interestingly, this increased empowerment for patients also humanized the physician and increased feelings of empathy towards them, such as when there was limited or time constrained interactions between physicians and patients. Instead of anger or frustration, there was an increased sense that physicians were ‘doing the best they could’ and were going to help.

*Empowerment equals empathy*

“I mean, everywhere you get that subset of people that are predisposed to see it [OUD] in [a negative] way. But you empower them with a tool to use for [OUD treatment], now you’ve not only gone from "Well, yeah, I empathize with these people" [with training], but ‘now I can empathize and help them’. And so I think that giving the tool, setting them up to understand how to use the tool, co-equal with the attitude shift, equals a true understanding. Because understanding without a tool is still just frustrating.”

This newfound sense of empowerment and empathy paves the way for whole-person care. The concept of whole-person care reflects the complexity of systems of care that focus on the
whole person as well as the system of care, instead of just the particular disease bringing the patient to the ED. When “we put a person at the center of his or her own care and look at all dimensions of health — not just traditional medical factors — we see a more complete picture” (Optum 2021).

Whole person care and overcoming bias

“I can usually get to a good place with someone who has some kind of foothold of lived experience with substance use. For the people that don't, that's where my wall happens, where it can generally be difficult for me to, without a time investment, get that person to a place where they see substance use in a way that informs their understanding of whole person care and structural determinants of health. So for [physicians] who don’t have lived experience, I think the answer is hardwiring [to provide that whole person care]. If you hardwire it, make it standard of care, then they'll do it because that's the expectation, right? All their peers are doing it. [So for me] the pathway gets us to whole person care by overcomes bias.”

I believe that overcoming biases around OUD allowed for providers to have a more open mind when considering the disease itself, and the various treatments available. One provider shared with me that before the BRIDGE, they actually had no idea that some patients with long-term drug use may need chronic management with MOUD, much like someone who takes statins for high blood pressure.
Bridging the Gap between Emergency Care and Downstream Treatment

“You know, fundamentally, I never knew [OUD] to be like a long term, Disease. [To me] MOUD was decreasing dose medicine to come off opiates- no opiate disorder medication is intended for lifetime use. But [I know now] it is a chronic relapsing disease, right. And that the brain chemistry can be changed, irrevocably. So yeah, obviously, relapse is definitely going to happen. And you might need chronic management for the rest of your life. I think people are starting to understand that [MOUD] is not always [a medication] to come off of. But I tell patients now, if you feel that you’re successful, and productive and healthy on the methadone, then advocate for yourself that you might need chronic management. And I feel like, that’s not something I would have done before. Because that was part of my limitations, being on the emergency side, like the [medication] initiation side, because I did very, very little with long term management issues”.

With this newfound knowledge around the chronicity of addiction also came a realization that there are ethical responsibilities around providing care for OUD that go beyond admitting someone for an infection or monitoring them after an overdose.

Ethical Responsibility to Provide Care

“[the BRIDGE has] reframed how I see OUD. [if] a patient came in with high blood pressure off the blood pressure medicines, we [ED doctors] would restart them right away, you know. So, [knowing] MOUD is approved as a long term treatment and not just a tapering dose to eventually come off of, but a lifetime kind of thing, then I feel like we
have an ethical responsibility to continue that. Really we're responsible for medical
treatment stabilization, not necessarily patient comfort, so I feel like that's where some
of the resistance to MOUD was coming from. It's like, 'well, they're not gonna die from
this, so I don't need to do this for them'. That kind of thing. But now [I get that] they're
not gonna die right here [in the ED] but they'll go out and use again, and overdose. I
think that's exactly what's happening. Doctors don't know that there's an indication for
these medications for chronic lifetime management. And so they assume that it's a short
term stopgap measure, that they don't necessarily need make them feel comfortable, or
get them a free high, I think. That was probably one of the main issues with physicians
not giving people MOUD [before].”

Ultimately, the BRIDGE has worked to add value to the system, for both patients and providers,
which is a core requirements to implement a new care process into medicine, particularly
somewhere as hectic as an ED.

Value in the system

“I think the pathway is incredibly important because of the flow in the ER. We sometimes
say, the patient care is sometimes the easy part, it's working the system that's the hard
part. The difference between a second year and a third year resident isn't necessarily
that they do patient care very differently. But the third year knows how to rock the
system and move their patients through twice as fast. And that's huge, actually, that's
really, really important. So the system has incredible value. But if you set up a system
and there's nobody there, you know, advocating for it, and there's no incentive or disincentive, then it's still not going to get used, right. So, I think there's probably a co-equally important value in both having a treatment and the general reduction of stigma. You’ve got to, you know, put the right infrastructure in place, but you also got to do the hearts and minds thing. I mean, if patients and providers are comfortable, they’re going to stick with it more. And that’s just fundamental, what it boils down to because the medicine part is easy, but it’s the social aspect that is so difficult with this.”

Towards a Functional Care Continuum

While the last two chapters have focused qualitatively on the before and after of BRIDGE implementation, and the next chapter will focus on quantitative outcomes and the implementation process, my aim is for all three chapters to be cohesively considered as an example of how to approach the building of a functional care continuum. What I mean by a functional care continuum is implementing a trauma-informed care continuum for patients (here, for OUD) that considers a trajectory-based model of care. One that functions as an interconnected bridge from ED stabilization to downstream treatment, with contingency plans for multiple considerations (e.g., what if the patient comes back to the ED, what if the patient does not show up to the treatment appointment, etc.). Also ever-present is real-time communication between the ED, downstream treatment partners, and the patient, which allows for the ability to fluidly adapt to a person’s changing treatment and supportive needs. This sort of continuum of care strategy may prove vital as we look towards building out clinical care pathways for structurally complex patient populations.
Chapter 6

Understanding Bridge Pathway Implementation Timeline, Challenges, and Outcomes

In this chapter I will present and discuss the BRIDGE (Building Recovery Integration for Drug Users into the Gateway of Emergency medicine) pathway implementation process and quantitative outcomes. Implementation comprises the planning, building, and successful executing of a clinical treatment pathway for opioid use disorder in the emergency department (ED), with the goal of it becoming fully integrated as a standard of care. I begin by presenting a pathway implementation timeline (Figure 6.10)—from September 2017 through September 2021—which details how myself, an attending physician, and a resident physician thought through each process of pathway planning, our progress on each step of the overall process throughout implementation, roadblocks that were encountered and how each roadblock was addressed/process was accomplished. Then, I discuss quantitative outcomes of the bridge pathway from September 2018-September 2021.

Quantitative outcomes are an essential component of an applied intervention, as these outcome metrics are how healthcare systems measure success. I begin the quantitative outcomes section with a discussion and presentation of demographics data (see Table 6.11), to give a snapshot of the patients enrolled in the bridge pathway, as well as factors that were related to several emerging challenges (e.g., out of county resident, legal hold status). I then
turn to a consideration of patient drug use data (see Table 6.12), which paints a picture of how many patients were able to access care through the bridge pathway, as well as how complex drug use can be; patients rarely use just opioids. Then, I describe clinical data that were collected about patient health experiences, including infectious disease, injection related complications, as well as significant health and mental health co-morbidities, as a means of understanding the complexity of the OUD patient population and the multi-tiered levels of care required for stabilization (see Table 6.13). Finally, I discuss outcome metrics associated with the bridge pathway, including the number of bridge patients to receive MOUD in the ED, follow-up status and referral type, average admission rates, recidivism rates, and the number of patients successfully engaged in treatment after the first index ED visit (see Table 6.14).

Following patient outcome data is benchmarking data from the American College of Emergency Physicians (ACEP) illustrating that out of 266 EDs across the country audited on multiple OUD-related metrics, the bridge pathway has enabled our hospital to lead the country in providing ED-based OUD care (Figure 6.17, 6.18. Benchmarking is the comparison of a performance or a process to the work or results (benchmarks) of others and is an important quality improvement measure in healthcare (ACEP 2022). Then, I evaluate some important considerations to healthcare implementation. Figure 6.19 illustrates these considerations, along with several challenges I encountered and details strategies I employed to either mitigate or overcome those challenges. The chapter will conclude with a consideration of how anthropological frameworks, including Critical Medical Anthropology (CMA), Clinically Applied

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26 An index visit was defined as the first ED visit (regardless of disposition) for a unique patient or any successive visits in which the patient had no prior visit or hospitalization during the preceding 30 days (Sabbatini et al 2016).
Anthropology, and Illness/Addiction Trajectories play an integral role in healthcare treatment implementation.

**MOUD Bridge Pathway Implementation Timeline**

This section presents an expanded overview of our implementation timeline, including issues encountered, necessary pathway revisions, and additional treatment and/or patient support integrations. Figure 6.1 illustrates a visual breakdown of the timeline, beginning in September 2017, and going until September 2021.

![MOUD BRIDGE PATHWAY IMPLEMENTATION TIMELINE](image)

*Figure 6.1: BRIDGE Implementation Timeline, 2017-2021*
In September of 2017, the opioid epidemic was at full tilt in the United States. Florida, and my county in particular, was experiencing an explosion of drug-related arrests, increased opioid-related hospital admissions, overflowing SUD treatment centers, and an alarming increase in opioid-related deaths. One of the county commissioners mobilized to find some solution for our own opioid crisis locally. The region’s rapidly intensifying opioid epidemic was also personal for this commissioner—in 2015 their sister died of an opioid-related overdose after ‘a traffic accident led to surgery, chronic pain, and ultimately – addiction’ leading them to ‘put their heart and soul’ into this initiative (Glasser 2018). The kick-off was a large gathering of county stakeholders in an all-day summit with multiple presentations and networking opportunities. Attendees ran the gamut, from sheriff’s deputies, ED physicians, politicians, treatment center CEO’s, community advocates, local bus drivers, peer recovery specialists, and more. I attended this summit with a physician from my ED 27 and around lunchtime we realized that there was an enormous opportunity for us to tackle a significant piece of this crisis, as the ED is often ground zero for OUD-related emergency care.

Right around this time, my ED ethnography on stigma in seeking care for acute opioid crisis was wrapping up. We had stacks and stacks of data, and an overflowing library of stories from patients. Some stories reflected exceptionally egregious experiences of stigma. One story will stick with me always:

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27 This physician would go on to help me build the BRIDGE pathway.
“The stigma...is so hardcore that it affects the level of care that you get. One of the times I was arrested and brought to the emergency department, they couldn't get any IVs into any of my veins, so they needed to make a port in my femoral vein. But they had this doctor who was practicing do it, and I had no say in anything. There was no local anesthesia, and he kept missing [my vein] and it was the most painful thing I have ever done in my life. And they all acted like I wasn't even a human being at all in that situation. I was handcuffed to the bed, and I was naked [because of the location of the port], and the male officers were there. Everybody was just standing around while the doctor was digging around and I screamed. That was probably the most horrific hospital moment that happened [to me]” (Henderson 2018:50).

Patients stated that whether they were in active use or long-standing recovery made no difference—as soon as the clinical team saw they had a history of addiction it was ‘game over’ and the care they received radically degraded. I knew to turn the tide of the opioid epidemic in my county, this had to change.

April 2018

Armed with the data from the ethnography, and galvanized by the summit we attended, an attending physician, a resident physician, and I became the core team to build what would become the bridge pathway. After several preliminary brainstorming sessions (see figure 6.2), one of the first issues we identified was not whether we could treat OUD in the ED, but where we would send the patients once discharged. This is often the issue with ED care and indigent
patients, their crisis is stabilized while in the ED, but they have no primary care physician or treatment plan for long-term stabilization, and inevitably must return to the ED because their disease is not adequately managed. During this time, we had just formed a standing meeting to sort out our Marchman Act process in the ED, which slowly became “hijacked” for bridge planning.

Figure 6.2: Late Night Pathway Planning (edited for anonymity)

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28 The Hal S. Marchman Alcohol and Other Drug Services Act of 1993, or more commonly referred to as the Marchman Act, provides for emergency assistance and temporary detention for individuals requiring substance use evaluation and treatment in the state of Florida (Marchman Act Florida, 2021).
April through September 2018

I vividly remember the first Marchman Act meeting I attended. I was aware of who several of the major opioid treatment stakeholders in the county were at this time, but I wasn’t professionally connected in this field yet; all the work I had completed thus far had been behind the scenes in the ED. So, when F, one of the physicians on the bridge pathway team, invited me to this meeting I didn’t quite know why. I arrived in the conference room prior to anyone else, and nerves mixed with a dose of Southern upbringing said that we couldn’t have a meeting without coffee and refreshments. Once these refreshments were on the table, the meeting attendees began trickling in. After we were all assembled and introduced, the lineup included CEOs and various other c-suite members from multiple treatment centers, the regions behavioral health managing entity, the hospital director of social work and case management, me, and F.

During that first meeting, I took notes and tried to absorb the different personalities in the room. Several firsts were happening around me—no one had built a hospital bridge pathway yet in the state\(^{29}\); hospitals typically do not reach out to downstream treatment providers to partner; treatment providers rarely inter-partner amongst themselves; the behavioral health managing entity had never worked with an ED. The first few meetings were a bit tense as we were all in uncharted waters. But everyone in the room was driven to find solutions that would stem the tide of deaths due to opioid overdose, and as everyone became

\(^{29}\) At the time of these meetings, the only bridge pathway in existence was the buprenorphine induction RCT at Yale medical, led by Dr. Gail D’Onofrio, which we used as a framework for our pathway.
increasingly comfortable with each other, and the territoriality faded into the background, the first version of the bridge pathway began to emerge.

Once buy-in from community treatment partners and the behavioral health managing entity was secured, and agreements were signed between the hospital and the treatment centers, it was time for Dr. F and I to get to work in the ED. We knew we would also need the buy-in from multiple teams in the hospital, which would involve gaining acceptance of and willingness to actively support and participate in providing OUD treatment in the ED via the BRIDGE. I spent many hours in the ED, engaging with myriad people from various clinical care teams. During these bursts of mini-ethnographic engagement, I was entrusted with numerous grievances, resentments, and examples of what providers though to be unfair regarding this or that treatment or policy. The heart of this discontent revolved around either a general unpreparedness for new policies and procedures or being left out of the creation process.

We consulted with psychiatrists, addiction medicine specialists, licensed substance use counselors, internal medicine and emergency medicine physicians and others to get their input in the process, creating multi-level trainings that would prepare both our team and the treatment centers for implementation. I spent the next six months, along with, F, and E, going back and forth across various departments in the hospital and medical college giving lectures, providing training materials, and answering questions (see Appendix L for examples).

We held several scheduled ‘lunch and learn’ trainings at the treatment centers where we brought in lunch and sat down with the various treatment teams in a listening session-style meeting. I wanted to understand what issues they were having in providing care, what difficulties they experienced if one of their patients needed to go to the hospital, or what they
would want us to include when building out the bridge. Perhaps most of all, I wanted them to feel seen and heard. Addiction medicine has long been relegated to the fringe of emergency care, with providers experiencing stigma themselves for providing care to *those people*. A nursing director shared with me that they had to go to the ED for something, and they had their work badge on. Once the nurse noticed the work badge, with the name of the treatment center, the care degraded. A *nursing director*, and the care degraded. I knew that involving multiple care teams (e.g., ED physicians, nursing, pharmacy, etc.) as equal partners in this process as much as possible would be vital\(^{30}\).

In addition to the trainings and listening sessions, there were the “nuts and bolts” practical matters that needed to be built as well as part of the bridge infrastructure. We needed to make sure we actually had the medication we planned on using on the pharmacy formulary and that it was stocked and ready to go; IT components for patient billing and order creation that needed to be built; and medical record chart notation templates (e.g., Clinical Opioid Withdrawal Scale (COWS) scoring model, DSM-V OUD diagnostic scoring, and patient care notation, please see appendix E, F, and I for examples). As this was happening, we were working on the process workflow (Figure 6.3) that front house staff including social work, case management, and the clinical research associates would use, and the clinical pathway (Figure 6.4) that physicians would refer to when initiating pathway treatment (please see appendix J for updated version).

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\(^{30}\) In 2019, we invited leadership and the medical director from our treatment center partners to attend a grand rounds physician lecture on addiction medicine. Grand rounds is typically a closed physician training, and this was the first time in the history of the hospital that addiction treatment providers had been invited to co-present.
TGH ED MAT PATHWAY WORKFLOW

PATIENT PRESENTS TO ED
Chief Complaint: Withdrawal, Substance Abuse, Anxiety, Back Pain, Abdominal Pain, Etc.

MAT Specialist uses COWS to score for withdrawal, and gains verbal consent for Social Work to meet with patient for MAT treatment.

MAT Specialist meets with provider and SW to discuss results of COWS. Provider and SW meet with patient to gauge readiness to stop using substances/MAT pathway enrollment

Upon Pathway enrollment (patient readiness and ≥5 COWS), provider dispenses 8/2 Buprenorphine dose to patient
  • Assess after 20 minutes. Repeat if necessary
    o Consult on-call MAT provider if patient is still ≥5 after two doses

Once patient is medically stable, SW will email MAT referral form to and arrange transportation

END PATHWAY

*IF patient is pregnant, substitute SUBUTEX for BUPRENORPHINE
*IF patient has overdosed, assess if they are appropriate for Marchman Act Pathway first.

*IF patient is going to be admitted, please place a non-emergent psych consult, with MAT PATHWAY as the heading. Please also place a non-emergent SW consult so that floor SW/CM can provide continuation of care.

ON CALL SCHEDULE FOR ENROLLMENT QUESTIONS/PATIENT CONSULTS

1st and 3rd Week of the Month: [Redacted]
1st and 3rd Week of the Month: Heather Henderson
2nd and 4th Week of the Month: [Redacted]
2nd and 4th Week of the Month: [Redacted]

Figure 6.3: First Version of MOUD Workflow, September 2018 (edited for anonymity)
September 13th, 2018

I was standing in my kitchen loading dinner dishes into my dishwasher on a rainy Thursday in September when my phone buzzed. It was F, “I just enrolled our first BRIDGE patient!” Eric, the patient in question, had recently overdosed from heroin after 15 years in recovery after learning that his brother had died suddenly in another state. I would eventually find out that his brother was the only family he had left; his parents had passed away and there were no other siblings. This meant he was now alone in the world—heavy for anyone, but especially heavy for someone in recovery. Eric was ashamed about relapsing, and it took some coaxing for him to say why he was really in the ED. But with the bridge infrastructure, what could have been an unproductive or stigmatizing encounter became business as usual. We had
solid treatment to offer him, medication to resolve his acute symptoms, and reliable downstream care even though he didn’t have insurance. I lost track of Eric in the years since the bridge started, but he reconnected with us recently. The nurse at the treatment center said they could hardly recognize him. No longer was he the gaunt man who quietly shuffled from place to place with his head down. Eric wanted us to know that he had a good job now; he was the manager of a local coffee shop. He had saved money for about a year and told us with a gleaming smile that he had managed to get all of his teeth fixed. He also lived in a nearby neighborhood next to the local community college campus and had enrolled in night classes. “I don’t know if y’all really know, but I was in such a bad way. Your program saved my life that night.” He whispered solemnly. I glanced over at the nurse who had done his initial intake to see a tear rolling from the corner of their eye.

January 2019

Things trundled along for the next three months, and the patients we enrolled increased. There was a particular complication though that seemed to be occurring frequently that we had not planned for: concurrent benzodiazepine use. Benzodiazepines, colloquially known as benzos, are a type of tranquilizing medication typically used for anxiety, with the most common ones being Xanax and Valium. The issue when benzos are taken with opioids lies in the fact that they are a similar class of medication, either one can cause sedation; taken together easily leads to over sedation and suppression of breathing, the primary causes of an overdose. In the early 2000’s mixing the two medications, often referred to as boosting became a common occurrence as opioid users discovered that mixing a pain pill with a benzo heightens
the high felt. This is especially useful if you cannot find a stronger opioid (Roxicodone was popular at this time) and only have a milder opioid (like tramadol) that will not produce the same euphoria or resolve withdrawal as well.

Between 2005 and 2009, the combination of opioids and benzos was the most common cause of overdose deaths involving more than one drug (NSDUH 2013). Withdrawal from benzos can also be deadly, involving seizures and psychotic reactions. Most outpatient treatment centers are not equipped to deal with a medical emergency such as this, and don’t have the infrastructure to medically manage the withdrawal stabilization which involves a 3-7 day tapering process of progressively lowered doses of the benzo until the patient is stable. We discovered that if the patient said the word benzo, they would not be able to be seen at the treatment center and would need to either come back to the hospital or go through a detoxification program to taper off of benzos. Patients would only be eligible for treatment once a urine drug screen (UDS) came back negative for the medication. Typically, each care handoff point that a patient encounters is an opportunity to become what’s referred to as lost to follow-up (LFT), or someone no longer engaging in the healthcare system. So now we have the index ED visit, the intake at the treatment center, the referral to either the hospital or detox, then patients have to go back to the treatment center with a negative UDS, and at this time over half of all patients we were enrolling reported concurrent benzo use. Clearly this was going to be a major source of complication. F and I surmised that if the patient is going to be sent to detox from benzos anyway, why don’t we reach out to the local facility directly to create a polysubstance pathway?
June 2019

I contacted the facility the patients were being referred to and began building out what a direct pathway from the ED to detox would look like. We were lucky in this regard—many counties in Florida do not have a dedicated detoxification facility, and patients often have to travel several counties away. Similar to the MOUD bridge, it took around six months of planning to launch this additional pathway. Since we were already building out a new process, I decided that we should add alcohol use disorder as well as polysubstance use. Acute alcohol intoxication and withdrawal account for a significant portion of annual ED visits, and severe withdrawal from alcohol is similar to benzos in that there can be life threatening seizures, referred to as Delirium tremens\(^{31}\).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (mild)</td>
<td>Anxiety, tremor, insomnia, headache, palpitations, gastrointestinal disturbances.</td>
</tr>
<tr>
<td>2 (moderate)</td>
<td>Mild symptoms and diaphoresis, increased systolic blood pressure, tachypnea, tachycardia, confusion, mild hyperthermia</td>
</tr>
<tr>
<td>3 (delirium tremens)</td>
<td>Moderate symptoms and disorientation, impaired attention, visual and/or auditory hallucinations, seizures</td>
</tr>
</tbody>
</table>

\(^{31}\) People usually refer to this as ‘having the DTs, or dt’ing.

Ironically, the front-line treatment for resolving this condition currently is a benzo taper. Due to the high risk of mortality and a lack of ED bandwidth to manage this condition, most ED patients with this presentation end up being admitted to the hospital for stabilization. This fact
is critically important, as these admissions were something I could point to in order to illustrate how this new pathway would vastly improve multiple hospital metrics.

With this new process, providers would monitor a patient’s blood alcohol level (BAC), stabilize with a benzo as needed, and once the BAC was 300 or below (the safe range for management at the detox facility), we would fill out the necessary paperwork to have the patient sent directly to the detox facility instead of being admitted to the hospital. This functioned similarly for polysubstance patients, where we would send the patient directly to the detox facility to taper off of benzos, and then they would go to the outpatient treatment center for intake and treatment. This new pathway resolved most of the care handoff points where a patient could potentially become lost to follow-up (LFT), but we were still missing that tracking and engagement from the detox facility back over to the treatment center. During this time, I was supervising a student for a human services internship, and they were open about their drug use history and recovery process. The more I thought about this intern and their recovery process, the realization dawned... who better to engage with patients and help them from one step of recovery to another than their peers?

I heavily relied on my lived experience (described in earlier chapters) to build the BRIDGE pathway and the relationships needed to maintain it. Could I also bring in other people into the ED with the lived experience necessary to engage with OUD patients and help them navigate along the trajectory from active use to recovery? I began talking to various people across my networks and learned that there was actually an official position for this that treatment centers have been utilizing for years. Peer Recovery Support Specialists are individuals who are in recovery from substance use or co-occurring mental health disorders.
Their life experiences and recovery allow them to provide recovery support in such a way that others can benefit from their experiences (NAADAC 2022). The Certified Recovery Peer Specialists (CRPS) credential allows people to use their lived experience and skills learned in training to help others achieve and maintain recovery and wellness from mental health and/or substance use conditions (FCB 2022). Our intern, Jules, had been with us all summer, and it was incredible how patients opened up to her during her shadowing shifts in the ED. I approached her one day and said, “If I find the money for this position, are you willing to stay on here with us, and take this certification course to become our first peer?” The answer was a resounding yes, so off I went to the managing entity to propose our plan.

There were several hurdles to integrate a peer into the ED. First was an initial bewilderment from ED leadership: “You want to put an ex-heroin user in an emergency room full of opioids?” Second, we discovered that in order to get the CRPS credential, the peer would need to be able to pass a level II background check from the Department of Children and Familied (DCF) which manages the credentialing process for a large portion of behavioral health workers in the state. As is common with a lot of people in recovery due to the punitive framework of addiction, Jules had felony charges that would need to be resolved before she could be hired. This triggered a lengthy exemption process, where she had to fill out a massive packet of paperwork, and we all had to submit character letters to DCF vouching for her and her recovery. Third, the managing entity would need to have Jules’ CRPS credential before an offer of employment could be made, which meant the exemption process would need to be complete, then the course taken, then the exam administered, then the credential assigned. We eventually made it through all of this rigamarole, and Jules continues to be an excellent
patient advocate, while simultaneously changing the hearts and minds of clinical staff on what it means to be in recovery. We were able to add another peer in 2021 and have two more in the hiring pipeline as of this writing. In sum, participant observation and other ethnographic research methods document the powerful impact that peers can have in ED-based OUD stabilization; there is an incredible value in someone being able to say they understand and mean it. If hospitals can equip Peers with an insider knowledge of how specific treatment pathways work, who to call at what location, what structural supports are currently available, etc., it was evident that the barriers to care began to fall away for OUD patients, especially those with a healthy distrust of the healthcare system.

*August 2019*

Another issue we encountered that second year was a lack of coverage for weekend hours at the treatment centers. The dosing clinic\(^{32}\) was open on Saturday and Sunday, but only to existing patients. New enrollments from the ED would have to wait for the center’s intake process during business hours where they would be assessed and formally admitted into treatment. We seemed to be hearing about not being able to get medicine on the weekend from patients so often that we began tracking weekend enrollments. Nearly 40% \((n=113)\) of bridge patients were being enrolled in the pathway during weekend hours (Friday afternoon through Sunday night). F, E, and I sat down to brainstorm solution. The treatment centers intake hours were pretty standard for the field, and even if they were to amend the hours, they

\(^{32}\) The term dosing clinic refers to the on-site pharmacy portion of treatment facilities where patients go either daily or weekly to receive MOUD.
did not have the clinical staff coverage to do so. The centers leadership were amenable to altering intake hours, but staff coverage kept emerging as the main barrier. At this time, E was interested in becoming boarded in addiction medicine, so F and I asked the CEO if they would be open to a novel solution to our weekend crisis.

After consulting with treatment center leadership and the physician contracting service for the hospital, we were able to sub-contract E as a provider for the treatment center, where they would moonlight as needed to complete the initial intake examination and paperwork, which would allow the patient to receive medication at the dosing clinic on Saturday and Sunday. The patient would then complete the rest of the formal intake process the following Monday morning. Essentially, this meant that the patient would not get sick over the weekend while waiting to get their medication, reducing the likelihood of relapse, or the patient disengaging in care. This contracting process demonstrates a deeper integration between EDs and community treatment partners, with the potential for a more seamless transition of care from the ED to downstream OUD care.

January 2020

In January of 2020, we were about 1.5 years into bridge implementation, and the pathway had stabilized enough to allow us the space to think deeply about solutions for patients that declined treatment during the ED encounter. How could we keep these patients

---

33 As more providers received their X-Waiver, a special designation from the DEA that would allow them to prescribe MOUD, we eventually integrated a 3-7 day buprenorphine prescription with each ED bridge induction.
safe and healthy if they were unable (for whatever reason) to initiate treatment at that time?

And so 2020 became the year of harm reduction\textsuperscript{34} integration.

\textbf{PRINCIPLES OF HARM REDUCTION}

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Please see \url{www.harmreduction.org} for a more expanded overview of the principles related to the practice of harm reduction.

\textbf{Figure 6.6: Principles of Harm Reduction (NHRC 2020)}

\textsuperscript{34} Please see \url{www.harmreduction.org} for a more expanded overview of the principles related to the practice of harm reduction.
I had already started implementing harm reduction education for patients, including a comprehensive guide on how to inject safely, how to avoid infectious disease, and how to self-taper off of opioids safely. What we didn’t have was a tangible means of preventing opioid overdose deaths, so I mobilized to find a way to provide patients with naloxone, a medication used to reverse an overdose. I found out from behavioral health colleagues that the hospital could register as a provider with the Overdose Prevention Program (OPP) run by DCF. The OPP ‘distributes free naloxone kits to individuals at risk of experiencing an opioid overdose, as well as to friends and family members who may witness an opioid overdose’. Registering as a DCF provider was a fairly simple process, and our treatment center partners supplemented us with their naloxone until our paperwork went through. The time consuming part was building out the infrastructure in the hospital.

First, I had to figure out where to store the naloxone. If there is a medication in the hospital, it must be stored in the pharmacy. At the hospital, there is a satellite pharmacy in the ED, an in-patient pharmacy for floor patients, and an outpatient pharmacy in a medical tower building adjacent to the main building the ED is in. It didn’t make sense to store it in in-patient pharmacy for ED patients, so the satellite pharmacy was the next ideal location. Unfortunately, the ED pharmacy did not have the room to store it. Second was the billing infrastructure. The naloxone was free from DCF, but how would it route through our system from the time the physician e-prescribed it to when the patient picked it up without charging the patient? Also, how would the pharmacy keep our stock of naloxone separate from their

---

35 Often, treatment centers will store their naloxone in medical pavilions, or nursing/clinical staff offices. At the outset I figured I could do the same with storing the naloxone in my office, but this was not possible.
own? Ultimately, we were able to store the naloxone in the outpatient pharmacy, and the pharmacy manager and IT helped figure out a billing process that zeroed out the medication. The physician would either e-prescribe or write the prescription to the outpatient pharmacy, and the patient would walk across the street and pick it up after discharge. The satellite pharmacy also agreed to keep 3-5 naloxone kits on hand for the patients we felt may not be able to make it to the outpatient pharmacy (e.g., acutely overdosed or wishing to leave against medical advice). And so, the free naloxone addition to the pathway came to be.

During this time, obstetrics approached us about partnering so that labor and delivery patients could have access to the bridge pathway and free naloxone. This would be our first expansion outside of the ED, so we had to figure out how we would get the patient referrals, who would go see the patient, how the patient would be enrolled in the bridge, and ensure that the right medications would be given. This is where psychiatry began to play a much larger role in our pathway. The psychiatry service had always come to see our ED patients when we placed a consult, but now they would be involved in the building and implementation of bridge expansion. I didn’t necessarily want to just expand into labor and delivery—if we were thinking about expanding the program outside of the ED we should try to really expand. So, in June of 2020, we began working with the chief of psychiatry, the rest of the psychiatric team, and the department of internal medicine on a protocol for MOUD bridge expansion to the entire hospital.

Buprenorphine, the medication we use, is a four to two part mixture. Four parts buprenorphine, and two parts naloxone. As naloxone has not been proven safe for pregnant women, we need to administer Subutex instead, which is the buprenorphine without the naloxone component.
June through December 2020

Expanding MOUD to the rest of the hospital went more smoothly than I thought it would. We followed the same process for ED implementation: a preliminary training period where I gave trainings and lectures to internal medicine physicians, floor nursing, inpatient pharmacy, social work, case management, psychology, etc., worked with inpatient pharmacy to ensure that the medication was stocked and ready, and met with various leadership teams from the different service lines to ensure a cohesive go-live date with expansion. We already had the IT and billing pieces figured out from the ED bridge, so we utilized that for inpatient as well. The only change in the process was an inpatient psychiatry consult to either reevaluate or continue MOUD. Most of the patients that would need to be started on MOUD first arrive in the ED.

Here, we would initiate the bridge pathway as usual, with an additional step of placing an inpatient psychiatry consult for medication continuation on the floor. For patients that did not come to the ED first (transfers, labor, and delivery), floor social work would request a psychiatric consult for initiation of the bridge pathway. Here, psychiatry would assess the patient, start them on MOUD as necessary, and send an in-basket message to my team (medical chart messaging) letting us know that x patient had been started on MOUD and for us to follow up. We would then put that patient on our inpatient follow up list, a member of the MOUD team would go see the patient, complete the bridge paperwork, and ensure a smooth transition from the hospital to the treatment center.

While working on the expansion protocol, it occurred to me that it might be possible to also fill another gap in care by creating a process for ED patients who come in acutely
overdosed from opioids. This issue had been on my mind for some time; a patient who comes into the ED acutely overdosed is not eligible for MOUD at that time, as you need to be 12-24 hour past your last use of short-acting opioids (Oxycontin, Vicodin, Percocet), and 72 hours past your last use of long-acting opioids (Methadone). In this scenario, patients are enrolled in the bridge without the medication component and will likely present to the treatment center in acute withdrawal. This leaves patients at a disadvantage when they are discharged into the environment where all of their triggers\textsuperscript{37} are, they start getting sick from opioid withdrawal, and are faced with the decision to either use to feel better or somehow make it to the treatment center to begin an arduous recovery process.

The process of getting sick in and of itself is a trigger—patients relate that as soon as the first symptoms arise, it triggers a panic to find something to feel better in order to stave off the more serious forms of withdrawal. Further, sitting through a lengthy intake process (this can sometimes take 5-6 hours) at the treatment center while in the throes of opioid withdrawal can cause patients to lose the initial courage they had to start the recovery process. We had more physicians than ever with their X-Waiver who were able to prescribe buprenorphine, could a process be created where the patient starts MOUD at home, and then transitions to the treatment center with peer support?

Figure 6.7 illustrates our at-home buprenorphine induction pathway, created with the help of psychiatry, internal medicine, and our peer specialists\textsuperscript{38}. Overdose patients receive a 3-7

\textsuperscript{37} Triggers are reminders that put people in a mental and emotional place of distress, pain, anger, frustration, and other strong emotions. In the case of addiction and recovery, triggers are often some sort of internal or external stimulus that causes a desire to use drugs or alcohol again. For example, an ex-smoker smells their old brand of cigarette being smoked. Instantly, their mouth tastes like the cigarette, and they long to light one up again.

\textsuperscript{38} Peer specialists were vital in ensuring that the language of the guide was appropriate, relatable, and easily understood.
day buprenorphine prescription at discharge and receive extensive counseling on the induction process before going home. Once at least five symptoms are felt, the patient is ready to start the induction process. It is important to wait until symptoms are felt because if the patient still has opioids in their system, the buprenorphine will cause what is referred to as precipitated withdrawal, and severe withdrawal symptoms can be felt in as little as ten minutes.

Precipitated withdrawal is the reason that overdose patients are not eligible for MOUD in the ED. If the patient has any question about the process, they can chat with a provider via telehealth, and with peers either over the phone or through video chat. Once the patient is stabilized, they can then decide to transition to the treatment center at a time that is convenient for them with peer assistance.

Figure 6.7: Buprenorphine Home Induction Patient Guide
January through September 2021

In January of 2021, we launched the state of Florida’s second legal syringe services program (SSP), IDEA Exchange Tampa. The SSP is an extension of our harm reduction efforts in the ED. For patients who decline treatment in the ED, and for anyone else in our community who needs help, people can now come to us via our mobile unit three days a week to receive multiple services. We exchange used syringes for new, unopened ones, along with all of the ancillary equipment needed to safely inject. There is also naloxone, free HIV and Hepatitis C (HCV) testing and linkage to treatment, wound care and linkage to treatment, mental health care linkage, housing assistance, insurance enrollment assistance, harm reduction education, and multiple Peers who are available for whatever the person needs, whether that is just to talk or be enrolled in our bridge. We are constantly thinking of ways to provide additional assistance to everyone enrolled at the exchange.

Many of our participants at the SSP are food insecure, so we started making sure there was some sort of food at every shift, even if it was just water and candy (sugar is often used to help mitigate the symptoms of withdrawal). We received donations that allowed us to cook a large dinner for Thanksgiving and Christmas, and we have plans to start a mobile pantry that participants can access during the exchange. We instituted a “First Friday”, where the first Friday of the month we have extended hours and a hot meal, and soon we will be adding “The Exchange” which will be a mobile thrift shop where participants can get clothes, shoes, bags,

40 All services at IDEA Tampa are anonymous and free of charge.
books, and other items for free as well. Below are some direct quotes from IDEA participants about the impact of the program on their lives:

“We were away from [the Exchange] for a few weeks, that’s when you realize how important it is. Not just for the needles but forming good habits around keeping yourself and your works clean. You are avoiding so many infections just by giving us alcohol swabs each time.”

“Thank God for [the Exchange]. I don’t know how many times you’ve saved my life.”

“I just came in for testing today, nothing else... It’s great to be able to check without the hassle from a clinic. Thank you so much for doing what you do.”

“Are you kidding? Half my friends would be dead if it wasn’t for the Narcan. You all are saving us.”

“Oh my God, it’s so hard out here sometimes... but at least I can come see you and know you’ll help. It means a lot when everything else is so tough.”

“For everyone that comes here there are like five others that you’re helping - with the Narcan especially.”

“My first wife died of endocarditis, and it just about killed me. But my girlfriend now is in [a recovery program] thanks to you and she’s doing pretty good. That’s what [the Exchange] does for me - it gives me hope.”

“You are angels, God’s angels, and these needles are keeping us so much safer. I am really grateful.”

Due to the lack of social infrastructure, treatment infrastructure, and recovery infrastructure, along with a general lack of knowledge around the addiction process, these people remain increasingly structurally vulnerable, so the work continues. In the ED, we continue to maintain the MOUD bridge pathway, which has now become a hardwired process, and continue to shore up its expansion throughout the rest of the hospital. We nurture our relationships with the community and are always considering new ways to innovate. Ultimately, we want to build a robust network of care, so that no matter where a person finds themselves in their addiction
trajectory, we are ready with the most up-to-date best practice treatments and initiatives to help.

Quantitative Pathway Outcomes: Measuring Successful Healthcare

The previous sections of this chapter have dealt with the BRIDGE pathway implementation process and timeline, as well as additional innovations/implementations we have achieved since the first BRIDGE patient was enrolled in September of 2018. This section covers electronic medical records data collected in this study, as well as important quantitative outcomes data based on metrics selected by hospital administration and common metrics that measure the success of ED-based treatment intervention. Table 6.11 is a demographics table of bridge pathway patients, Table 6.12 reflects rates of polysubstance among OUD patients, while 6.13 illustrates common co-morbidities, both physician and mental. With these tables, I hope to demonstrate the complexities of this patient population, and why it is often considered challenging to build out care pathways for OUD due to the complicated social structure and non-linear trajectories of addiction. Table 6.14 highlights quantitative outcomes specific to BRIDGE patient treatment, while Figures 6.17 and 6.18 show the American College of Emergency Physicians (ACEP) EQUAL opioid benchmarking data related to OUD treatment for 2021, with specific outcomes that compare this ED to other EDs across the country.

The ACEP aims for this initiative are “reducing opioid-associated harm through safer prescribing and the implementation of evidence-based interventions, include helping EDs to:

1. Improve opioid prescribing safety
2. Adopt harm reduction strategies such as naloxone prescribing and initiate treatment of opioid use disorder (OUD) with buprenorphine.

3. Implement alternatives to opioids (ALTO) (ACEP E-QUAL 2022).

Table 6.1 reflects the demographics data extracted from the electronic health record (EHR) for all BRIDGE enrollments. Regarding age distribution, over half of patients (65%) presenting to the ED with an opioid-related issue were 40 years old and younger, which aligns with what was observed in new hepatitis C infections among BRIDGE patients (table 6.13). Of the patients born before 1980, many were chronic pain management patients that were removed from treatment once more strict opioid prescribing practices went into effect in Florida, forcing patients to turn to other means to address their pain/OUD. Gender was evenly split, with a minor tilt towards male patients, and an extremely small percentage of transgender. I am unsure if this reflects the true reality of this patient demographic, however, as many patients are leery of self-disclosing transgender status due to perceived stigma and discrimination. The ethnicity of BRIDGE patients was overwhelmingly White (72.6%), though I do not believe this is an accurate representation of persons in my county experiencing OUD, but rather a representation of persons who most often seek care for OUD complications. At IDEA Exchange, we are starting to see a more diverse sample of patients, which may be the result of social capital built, the presence of a safe space outside a traditional clinical setting, and diverse representation among IDEA staff.

The remaining demographic data points, out of county residency, insurance status, homelessness, legal hold status, and weekend enrollment, were used operationally to inform linkage to care for BRIDGE patients. Of note, only 9% of patients enrolled had any form of
private health insurance, while nearly 30% had no insurance at all. The remainder (40.8%) had either Medicaid, Medicare, or the local county insurance. A lack of insurance or being underinsured, can make it almost impossible for a patient to attain sustainable care for OUD. This was a key consideration during pathway planning, as I had interned at a methadone clinic and was familiar with treatment pay structures. For BRIDGE patients who were un/under insured, grant funding was set aside that allowed them to receive a treatment subsidy, lowering the daily cost of treatment to as little as three dollars a day (down from $14-$20). There were special accommodations made if a patient still could not pay the three dollars a day, so no patient was turned away due to inability to pay. Homelessness often signaled that we needed to find residential treatment for the patient, or some sort of interim housing solution. Two of our most utilized housing solutions included a local respite center where patients could stay for 30 days, and the Salvation Army, which has a residential OUD treatment program as well as a general homeless shelter.

For legal holds, patients historically experiencing OUD complications were often either placed on a Baker Act, or Marchman Act legal hold as a means of treatment. That the BRIDGE legal hold hovered around ten percent reflects an improvement in providing care for OUD patients. If a patient was not considered a harm to themselves or others when we evaluated them for BRIDGE enrollment, we would be able to rescind the legal hold, and proceed with regular pathway enrollment. Lastly, tracking weekend enrollment status is what allowed us to create the contract between the hospital provider and the community treatment center for weekend coverage, as well as increasing the number of physicians with the ability to prescribe buprenorphine.
Table 6.1: BRIDGE Patient Demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Bridge Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total n</td>
<td>500</td>
</tr>
<tr>
<td>Age, n (%)</td>
<td></td>
</tr>
<tr>
<td>1920-1950</td>
<td>1 (0.02%)</td>
</tr>
<tr>
<td>1951-1960</td>
<td>33 (6.6%)</td>
</tr>
<tr>
<td>1961-1970</td>
<td>48 (9.6%)</td>
</tr>
<tr>
<td>1971-1980</td>
<td>93 (18.6%)</td>
</tr>
<tr>
<td>1981-1990</td>
<td>198 (39.6%)</td>
</tr>
<tr>
<td>1991-2001</td>
<td>127 (25.4%)</td>
</tr>
<tr>
<td>Sex, n (%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>213 (42.6%)</td>
</tr>
<tr>
<td>Male</td>
<td>285 (57%)</td>
</tr>
<tr>
<td>Transgender</td>
<td>2 (0.04%)</td>
</tr>
<tr>
<td>Ethnicity*, n (%)</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaskan</td>
<td>2 (0.004%)</td>
</tr>
<tr>
<td>Asian</td>
<td>6 (0.1%)</td>
</tr>
<tr>
<td>Black or African American</td>
<td>55 (11%)</td>
</tr>
<tr>
<td>White</td>
<td>363 (72.6%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>27 (5.4%)</td>
</tr>
<tr>
<td>Don't know/Declined to answer</td>
<td>16 (0.33%)</td>
</tr>
<tr>
<td>Other</td>
<td>31 (6.2%)</td>
</tr>
<tr>
<td>Out of County Resident, n (%)</td>
<td>87 (17.4%)</td>
</tr>
<tr>
<td>Insurance Status, n (%)</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>45 (9%)</td>
</tr>
<tr>
<td>Public</td>
<td>204 (40.8%)</td>
</tr>
<tr>
<td>County Healthcare Plan</td>
<td>104 (20.8%)</td>
</tr>
<tr>
<td>None</td>
<td>147 (29.4%)</td>
</tr>
<tr>
<td>Homeless, n (%)</td>
<td>204 (40.8%)</td>
</tr>
<tr>
<td>Marchman/Baker Act, n (%)</td>
<td>50 (10%)</td>
</tr>
<tr>
<td>Weekend Enrollment, n (%)</td>
<td>163 (32.6%)</td>
</tr>
</tbody>
</table>

*based on medical record categories

With Table 6.2, I want to demonstrate how complex it can be to provide care for OUD. MOUD is designed for opioids, but rarely does a patient ‘just’ use opioids. Physicians get nervous in the best of times with just one substance, but many of the patients I encountered, either face to face, or through chart review, used no less than three substances (and sometimes more than ten). Under polysubstance, 39.8% of all pathway patients used three or more substances. Of those with less than three, stimulants, benzodiazepines and cannabis were most used. Though risks of stimulants and benzodiazepines and concurrent opioid use have been discussed earlier in this study, I want to highlight cannabis. While cannabis is usually seen
socially as innocuous, in the context of chronic pain and OUD, a recent study in the Journal of Addiction Medicine suggests that “...compared to opioid use alone, opioid and cannabis co-use was associated with elevated anxiety and depression symptoms, as well as tobacco, alcohol, cocaine, and sedative use problems, but not pain experience” (Rogers et al. 2019). This can be especially true of patients with other comorbid mental health issues, such as bipolar disorder, as cannabis binds to opioid and cannabinoid receptors in the brain which can result in rapid mood cycling and psychiatric medications becoming less efficacious.

Even among opioids, 18.2% of BRIDGE patients report using three or more opioids as last opioids used. Noteworthy in this table is that only 22.6% of patients reported trying MOUD, like methadone or buprenorphine. Of the patients who’d previously engaged in MOUD, 55.7% had tried buprenorphine. This is significant, as buprenorphine is commonly traded amongst people to resolve withdrawal, much like antibiotics to resolve an infection, without an understanding of exactly how the medication works. A plethora of patients I spoke to were convinced that they ‘were allergic’ to buprenorphine, when what had happened is they took the medication while opioids were still present in their system, which then threw them into withdrawal. The pathway played a vital role in educating patients on both the medication and treatment process, allaying fears, and making space for giving buprenorphine a second chance.
Table 6.2: Drug Use Data at Time of Enrollment

<table>
<thead>
<tr>
<th>Last Opioid Used, n (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>227 (45.4%)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>91 (18.2%)</td>
</tr>
<tr>
<td>Methadone/Buprenorphine</td>
<td>25 (5%)</td>
</tr>
<tr>
<td>Oxy/Roxi/Hydrocodone</td>
<td>20 (4%)</td>
</tr>
<tr>
<td>Morphine/Dilaudid</td>
<td>37 (7.4%)</td>
</tr>
<tr>
<td>Vicodin/Percocet</td>
<td>9 (1.8%)</td>
</tr>
<tr>
<td>Other Unknown Opioid/Multiple</td>
<td>91 (18.2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous MOUD Engagement, n (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>113 (22.6%)</td>
</tr>
<tr>
<td>No</td>
<td>218 (43.6%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>169 (33.8%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous MOUD Engagement Medication, n (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>46 (40.7%)</td>
</tr>
<tr>
<td>Buprenorphine/Subutex</td>
<td>63 (55.7%)</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>3  (2.6%)</td>
</tr>
<tr>
<td>Vivitrol</td>
<td>1  (.08%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Polysubstance Use, n (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>23 (4.6%)</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Stimulants</td>
<td>83 (16.6%)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>326 (65.2%)</td>
</tr>
<tr>
<td>Barbituates</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>131 (26.2%)</td>
</tr>
<tr>
<td>Multiple/Other</td>
<td>199 (39.8%)</td>
</tr>
</tbody>
</table>

Table 6.3 reflects how physiologically complex patients experiencing OUD complications can be. This is largely in part due to structural inequality, a lack of preventative or primary care, a family history of mental health issues that are often triggered by trauma, and difficulty in perceiving risk, which is a component of active addiction. Structural inequality and a lack of access to care is evident in that 89.6% of all BRIDGE patients reported having three or more concurrent chronic health conditions, with chronic pain and injection related issues being the most common at 28.2% and 25.4%, respectively. The incidence of HIV was 2.6%, while the incidence of Hepatitis C was 84.8%, with 30.5% of total infections being newly diagnosed.
Regarding mental health, 26.2% of all patients reported being diagnosed with three or more mental health issues, with depression, anxiety, and bipolar I/II disorder being most common. In terms of depression and anxiety, it’s a bit of a chicken and egg argument. Did these issues come first and the patient self-medicated the symptoms, or did the patients opioid use affect vital mood chemicals like serotonin and norepinephrine, resulting in anxious and depressive symptoms? Perhaps most telling was the abundance of bipolar I/II disorder patients. Though BPD represented 13.2% of the sample, of the patients reporting multiple mental health issues (26.2%), BPD was often included. It struck me during this study how prevalent OUD and BPD is—this reality has future implications for new care pathways that co-locate mental health and substance use issues.

Table 6.3: Significant Health Comorbidities at Time of Enrollment

<table>
<thead>
<tr>
<th>Total n</th>
<th>500</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infectious Disease, n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>13  (2.6%)</td>
</tr>
<tr>
<td>Hepatitis C (Antibody reactive)</td>
<td>424  (84.8%)</td>
</tr>
<tr>
<td>Chronic Hepatitis C (viral load detected)</td>
<td>226  (53.3%)</td>
</tr>
<tr>
<td>Newly Identified Chronic Hepatitis C</td>
<td>69  (30.5%)</td>
</tr>
<tr>
<td>Dual HIV/Hepatitis C Infection</td>
<td>20  (8.3%)</td>
</tr>
<tr>
<td>Sexually Transmitted Infection</td>
<td>33  (6.6%)</td>
</tr>
<tr>
<td><strong>Chronic Health Issue, n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>46  (9.2%)</td>
</tr>
<tr>
<td>Diabetes Mellitus 1/2</td>
<td>23  (4.6%)</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>15  (3%)</td>
</tr>
<tr>
<td>Injection Related Issues*</td>
<td>127  (25.4%)</td>
</tr>
<tr>
<td>Liver Disease/Cirrhosis</td>
<td>10  (2%)</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>141  (28.2%)</td>
</tr>
<tr>
<td>Three or More Chronic Health Issues</td>
<td>448  (89.6%)</td>
</tr>
<tr>
<td><strong>Significant Mental Health Issue, n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>76  (15.2%)</td>
</tr>
<tr>
<td>Bipolar I/II Disorder</td>
<td>66  (13.2%)</td>
</tr>
<tr>
<td>C/PTSD</td>
<td>6  (1%)</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>47  (9.4%)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>5  (1%)</td>
</tr>
<tr>
<td>Multiple/Other</td>
<td>131  (26.2%)</td>
</tr>
<tr>
<td><strong>Primary Care Physician, n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>117  (23.4%)</td>
</tr>
<tr>
<td>No</td>
<td>384  (76.6%)</td>
</tr>
<tr>
<td><strong>Opioid Overdose, n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosis at time of Enrollment</td>
<td>51  (10.2%)</td>
</tr>
<tr>
<td>Historical</td>
<td>334  (66.8%)</td>
</tr>
</tbody>
</table>

*Neces, Cellulitis, MRSA, Bacteremia, Osteomyelitis, Endocarditis
Table 6.4 reflects specific patient outcome data for 500 BRIDGE enrollments from 2018-2021. These outcomes show significant promise in offering MOUD in the ED and a warm handoff to downstream care, which is a connection made by the ED team to the downstream treatment team, in front of the patient, with Peers available to assist throughout the process from ED discharge to downstream treatment engagement. In treating health concerns like addiction, a warm handoff approach can have additional benefits past ensuring a smooth care transition, including 'building a patients trust in clinicians, and reducing stigma about behavioral health care (Pace et al.. 2018:346). All 500 patients received a referral at time of treatment in the ED, and 67% received MOUD initiation at time of enrollment. In addition to MOUD, 65.4% of all patients received a free prescription of naloxone, and 15.2% of all patients received a prescription for buprenorphine to bridge them to their community provider appointment. I want to highlight BRIDGE follow up. Of patients that come to the ED for emergency care, say for a diabetic or hypertensive crisis, 22% will follow up with a community provider for after-visit care. Of patients that received MOUD and a peer-led referral to treatment, 73% successfully followed up to downstream care, 51% higher than the national average.

Of the 73% that successfully followed up for some form of treatment (outpatient, intensive outpatient, residential or detox), 60.8% had either completed treatment or were still engaged in care at 90 days. Of the patients that came back more than three times for OUD-related issues (6.8%), 44.1% were successfully engaged in care 90 days after the initial index ED visit. Patients that come back to the ED for the same issue as the index visit, known as recidivism, is important to consider. When speaking to one physician in another healthcare

41 This rate of 73% reflects the same rate of success as the D’Onofrio et al. (2015) RCT.
system about providing buprenorphine for OUD patients, they intoned that it would “be like feeding stray cats” and we would have a line of drug-seeking patients out the doors. However, as you can see, BRIDGE recidivism was around 8% less than normal ED recidivism. Even of those that did return more than twice, almost half were successfully engaged in care, largely owing to the resolution of structural issues, including financial issues, housing, childcare, and transportation.

Table 6.4: BRIDGE Pathway Outcomes Data

<table>
<thead>
<tr>
<th>Total n</th>
<th>500</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOUD at Time of Enrollment, n (%)</td>
<td>335 (67%)</td>
</tr>
<tr>
<td>Buprenorphine/Subutex</td>
<td>289 (86.2%)</td>
</tr>
<tr>
<td>Methadone</td>
<td>46 (13.7%)</td>
</tr>
<tr>
<td>Ineligible</td>
<td>20 (5.9%)</td>
</tr>
<tr>
<td>Other SUD Enrollment</td>
<td>145 (29%)</td>
</tr>
<tr>
<td>Referral Type, n (%)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>333 (66.6%)</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>25 (5%)</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>14 (2.8%)</td>
</tr>
<tr>
<td>Detoxification Treatment</td>
<td>128 (25.6%)</td>
</tr>
<tr>
<td>Follow-up Status, n (%)</td>
<td></td>
</tr>
<tr>
<td>At Enrollment*</td>
<td>365 (73%)</td>
</tr>
<tr>
<td>Still Engaged at 90 days</td>
<td>222 (60.8%)</td>
</tr>
<tr>
<td>MOUD Bridging Prescription**, n (%)</td>
<td>51 (15.2%)</td>
</tr>
<tr>
<td>Naloxone Prescription, n (%)</td>
<td>327 (65.4%)</td>
</tr>
<tr>
<td>Admission Rate, n (%)</td>
<td>173 (34.6%)</td>
</tr>
<tr>
<td>Recidivism Rate***, n (%)</td>
<td>34 (6.8%)</td>
</tr>
<tr>
<td>Numer of Repeat Enrollments Successfully Engaged after Index Visit, n (%)</td>
<td>15 (44.1%)</td>
</tr>
</tbody>
</table>

*National data reflects a 22% follow-up rate for post-discharge care
**Bridging Prescriptions were not started until 2020
***ED recidivism rates range from 10-15% on average
Figures 6.8 and 6.9 reflect the ACEP E-QUAL Opioid Initiative, demonstrating where our hospital ranks in seven different metrics as compared to nearly 300 other hospitals across the country.

The seven metrics measured (6.18) are:

1) Ratio of Overdose to OUD patients

2) Substance Use Evaluation in the ED

3) Take Home naloxone Offered in ED

4) Treatment Administered in the ED

5) Treatment Prescribed at Discharge (bridging script)

6) Overdose Prevention or Harm Reduction Discussed

7) Referral to Substance Use Disorder Treatment

Due to successful BRIDGE pathway implementation, our hospital is now in the 99th percentile out of 266 participating EDs across the nation for all seven metrics of OUD-related care.

Further, we received national recognition for these rankings, including an award from ACEP in 2021.
Figure 6.8: American College of Emergency Physicians Opioid Care Benchmarking Report
While it is wonderful that the BRIDGE was so successfully implemented as to receive national recognition, building a successful applied intervention targeting emergency care is not an easy feat. One of the questions I receive most often is to explain how this was done. The following section, while not often found in dissertations, is an applied outcome of this research.
for clinical treatment pathway implementation, geared towards healthcare professionals and other medical anthropologists interested in doing this sort of applied work. First, I will consider some common issues that I experienced during the implementation process, then I offer a roadmap based on my own experiences, for how to approach the implementation of novel care strategies.

**Common Issues in Healthcare Implementation: Organizational Culture, Knowledge, and Funding**

The largest circle of Figure 6.19 presents three of the most common issues to encounter when trying to implement a new healthcare intervention; here I will focus on the ED as this was my primary field site. In short, what is the organizational culture of the ED you are working in? Is it one that would accept an intervention or treatment pathway? What is the current knowledge base regarding the intervention or treatment that is proposed, and who is going to pay for it?

![Figure 6.10: BRIDGE Implementation Challenges](image-url)
Organizational Cultural Context, Interactions, and Power Relations

The first step was to assess the organizational culture of the ED at the hospital where I was working, e.g., patterns of communication, observed behaviors, perceived willingness to adopt new care strategies, etc. I was lucky in this, as I had recently completed a year or so of ethnographic work which allowed me to really sit and talk with people. When thinking about the cultural contexts of the ED, I would say there are two distinct organizational cultures you have to consider:

1) **What is the organization’s administrative culture? Is it one that resists or easily accepts changes?**

2) **What is the organizational culture among and between staff groups? Who will be your champions? Are there detractors that will bog down your implementation process?**

First, ascertaining what metrics are most important to the organization that is implementing change; in the ED, that is a patient’s average length of stay (los), the number of times a patient comes back to the ED following discharge from an index visit (recidivism), and how quickly a patient moves through the ED encounter (throughput times) were all important metrics. Once you know these metrics, you can then devise a plan to illustrate how implementation of your program is going to improve them. For example, patients treated through the bridge pathway on average had a 33% shorter los versus OUD patients before pathway implementation, measured in the ED as throughput⁴², and an 8% decrease in recidivism compared to non-pathway OUD patients.

⁴² ED throughput, measured by a patient’s length of stay (LOS), includes increments of time between the arrival to and departure from the ED. Reducing an ED’s LOS promotes quality care and patient safety and is often used as a key performance indicator for hospital ED’s (Probus et al. 2020).
The second piece can be a bit more tricky. Not only do you need to consider the culture among individual groups of ED staff (e.g., physicians, nurses, social workers, etc.) but you must also consider the culture between these groups as well as any individuals within a particular group that may stall your progress. Though this can seem overwhelming, the best way to start is by selecting individual groups you will be working most intimately with and then moving outward until saturation. When considering groups in my ED, I began with the physician group. Who are my supporters, who is ambivalent, who will put up the most resistance? I then, employed this same process with the rest of the groups. Lean on your supporters, take time to converse with the ambivalent individuals and get their thoughts and input; the most time should be spent devising strategies on how best to engage with the resisters. In my own personal experience (your mileage may vary) I found the loudest resisters were usually the ones with the most painful past regarding some form of SUD. Each time I heard something stigmatizing or saw that a patient was receiving a varied level of care due to their OUD, I took the time to sit down, level with the individual and really talk through their thought process.

I would often begin with addressing and defining what structural determinants of health (SDH) are, which can be a good resolution to “why can’t they just stop using drugs” or “they’re making a choice to use, if they really wanted to get clean they would” or “there are real patients here that need care, and I have to waste my time on someone that won’t stop getting high.” You can usually get to a good place with this tactic, though not always. I had the benefit of extensive lived experience around SUD and mental health issues, so when a topical discussion of SDH wasn’t moving the needle, my ace in the hole was being able to say that I understand their pain and frustration around OUD, and really mean it. If I felt it would help, I would share
personal childhood stories, stories of triumph I’ve witnessed, and, when the bridge pathway was operational, success stories specific to patients from our ED. Most of the time, these passionate exchanges were enough to get the patient care back on track, and position that provider to be more successful in future treatment encounters with OUD patients.

However, sometimes none of these tactics work. I can vividly recall one conversation I had with a case manager who refused to provide an OUD patient with a bus pass because they “already got one, and this isn’t a charity.” I steeled myself to go and speak with them; this wasn’t the first time I’d had an issue with this particular person. As soon as I came around the corner of the unit desk and they saw me, they became immediately defensive. “I already told Macy that he couldn’t get another bus pass, he was just here last week and got a bus pass. We’re not here to just give out bus passes!” I started in on my usual SDH discussion in an attempt to explain why perhaps the patient had not managed to stabilize their life enough to resolve their transportation issues in the time since we’d seen him last week. Nothing I said seemed to make a difference; there was a vitriolic rebuttal to every point that I offered. After nearly ten minutes of fruitless discussion, with many increasingly wide-eyed colleagues turned toward the case manager, they said, “Well, I admit that maybe I’m not the person to care for these patients. Macy can take over.” Macy lightly jogged down the back hallway to have a word with me as I was making my way back to my office. “Hey,” she said. “I know they can be pretty harsh, but their father was an alcoholic. I think they had a pretty rough childhood.” And there it was. The painful past with SUD.

Not all healthcare implementation is going to be uniform, and not all treatment pathways will involve such a socially and medically complex patient population. However, no
matter what implementation you are trying to build, the key to successful implementation is investing time in the beginning to sit and listen to people. Conduct as many mini-ethnographies as possible. Address the root cause of why someone might feel the way they do, or what they may need to be more successful. In all, I spent nearly 18 months on this process, as I think the pre-implementation phase is the most vulnerable, and the phase where you should spend the most time. While conducting these ethnographic bursts, I also used this time to ascertain a particular groups’ level of knowledge surrounding OUD and integrated that into planning tailored trainings and lectures for both individuals and multiple groups.

**Knowledge**

Assembling a baseline measure of what providers knew and didn’t know around OUD and MOUD treatment allowed the bridge pathway to begin to take shape. Once you know what knowledge base you have to work with, you get a greater sense of areas that can be built up fairly easily, versus gaps in knowledge that need significant shoring up. There is information that every single group needs to know, and then there is information that can be tailored to specific groups in ways to achieve the greatest impact. For example, every group needed to know that MOUD was a front-line, best practice treatment for OUD, and this is what we planned to implement in our ED. However, how this information is delivered needs to vary for maximum impact; craft a lecture on mu, kappa, and delta receptors for social workers and they may fall asleep, and vice versa.

For physicians we focused on the complex physiology of OUD, grounding it firmly into the chronic, relapsing disease model that they are familiar with, as well as explaining how this
treatment would help improve their practice. For social work, we drove home the SDH model, as well as how the bridge pathway would greatly aid them in patient care and referral. For pharmacy, we focused on the actual medication, including how it functions, the legalities around its administration, and other medications with a similar profile. No matter how you tailor the information though, it always needs to be tied back to how this implementation is going to improve outcomes, whether that be specific metrics, general patient encounters, or workplace quality of life. Bridge pathway implementation also addressed our lack of treatment structure for OUD in the ED, and we utilized peer recovery specialists to address patient engagement, which I will discuss in more detail later in the chapter. One question we tended to encounter regularly, however, was “All this sounds great, but who’s going to pay for it?” This is a fair question when wanting to start a new program, and one that needs to be thoughtfully addressed.

Funding

Both myself and the physicians that I built the bridge pathway with are of the mind that if you do the work, the money will come (which is to say that we started this with no money). This is not always practical or logical depending on what you are attempting to implement and the organization you hope to implement within. I was fortunate enough to be supported by grant funding and split my time between grant responsibilities and bridge pathway building. Working in an academic medical system with a research focus, I also had clinical research associates to lean on in the early days of the bridge pathway to assist in answering physician questions and help usher patients through the bridge pathway process. I further had resident
physicians in need of scholarly projects, which supplied me with an extra set of eyes for data analysis, extra input on pathway development, and a lead resident in charge of pathway dissemination and implementation among their peers. And the funding did come. A year after pathway implementation our ED was selected for a National Institutes of Health (NIH) randomized controlled trial (RCT) for a new ED-based OUD treatment. I am aware, however, that our status as an academic health system also helped us secure this grant. I will say that I believe implementations such as this are possible with limited or no funding, but you need dedicated champions to help drive the process forward. One of the outcomes of this work for us is that we hope to use our implementation experiences to create a template for other EDs across the country; a tentative drag and drop implementation plan that would allow them to stand up a tailored OUD treatment process in a relatively short timeframe. The next section will cover our implementation experiences, organized by an implementation timeline.

Re-Examining the Role of Anthropology in Clinical Spaces

This section introduces the concept of ethnographically informed care, which is utilizing ethnography as a method to understand the physical, social, cultural, economic, and political characteristics of a healthcare space to inform the design, implementation, and evaluation of an applied clinical intervention. A principle reason an ethnographically informed care approach is critical to creating a successful intervention is because context matters. While this intervention was successful in this hospital/community, each healthcare space will require

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43 In large teaching hospitals, resident physicians drive a lot of the initial interactions with patients. Residents who were well-trained in the bridge were able to identify patients, know the treatment protocol, and report the tentative treatment plan back to the attending physician for approval in a fairy smooth process.
different tactics, partnerships, and ethnographic approaches. The BRIDGE pathway might have looked vastly different even one county over. This method is a means to think through how interventions can be built for vulnerable populations in culturally and structurally unique clinical settings, and every clinical setting and the community it is situated in is unique. The following section offers a means to for anthropologists to enter the clinical space as a field site and point of intervention, including what needs to be observed, who needs to be interviewed, what documents and policies need to be reviewed and how the community needs to be involved.

What needs to be observed?

For this study, it was recognizing the critical nexus of interaction that happens between patients and physicians or other clinical teams when care starts to break down as addiction enters the scene. Prior to the BRIDGE pathway, almost every patient I have ever spoken with has affirmed that as soon as the care team finds out that they are in the ED for an OUD-related issue, the care breaks down almost immediately. Other anthropological work confirms this (Garcia 2010) where patients report that they never mention addiction when seeking care as ‘staff may not even examine or treat their presenting condition’ (277). I refer to these breakdowns as a structural void; these liminal spaces that represent a gap in knowledge, training, or empowerment which provides an opportunity to intervene. When considering where to start observations, I chose to start where I was most comfortable, by observing and interacting with patients. I sat for hundreds of hours with patients suffering from opioid use complications during my master’s thesis, and these hours uncovered rampant stigma both
among healthcare workers towards OUD patients, and stigma towards healthcare workers from OUD patients.

Figure 6.11: Dynamics of Opioid Addiction (Henderson, 2018)

Figure 6.11 highlights the dynamics I witnessed related to stigma and how it affected all levels of emergency care and life in general. Though the principle barrier in this study was stigma, it also uncovered the reality that “each member of this crisis [including patients, physicians, law enforcement, politicians, and others] bring their own thoughts, feelings, emotions, and lived experience to the table” (Henderson 2018:69). I understood that this stigma would need to be reduced in order to build out an effective applied intervention for OUD, but it was the process of observing interactions with physicians and patients over and over again in which I realized that it was in the specific interaction during the ED encounter that stigma was both created and perpetuated, and offered the best chance of intervention. In order to begin moving away from that type of interaction, toward an applied intervention, there would need to be a shift away from binary approaches to addiction, toward more inclusive solutions that increase access to sustainable follow-up care after the initial acute crisis.
Once I became more comfortable in the space, I then began to observe physicians and healthcare teams more closely during care encounters for OUD patients. What was happening during the acute clinical encounter that no care was being given/received? As I began to observe physicians and care teams more, the concept of learned helplessness, described in earlier chapters, (to me) began to emerge on all sides. Physicians, social workers, case managers, police officers, and patients had all largely given up on the successful medical management of OUD due to a staggering lack of treatment options or access. And this lack of access did not just occur in the ED space. Social workers were unable to find placement for patients in detoxification or rehabilitation centers. Patients were unable to find (or afford) medication and other therapeutic help. Law enforcement was left with the blunt tool of incarceration when clearly there were deeper structural issues occurring that they couldn’t ‘arrest their way out of’ (Evans 2018). Physicians were often relying on a binary solution of either a psychiatric legal hold or discharge as the two paths forward for patient care. In summation, observe everything beginning with where you are most comfortable, until important themes and key actors start to emerge. Reading pre-existing literature and previous research done in clinical spaces related to the intervention you are interested in creating will also provide guidance as to what major themes may emerge, for example literature on community-based participatory research in healthcare settings.

Who needs to be interviewed?

Each clinical space has its own cultural practices that must be understood in order to be navigated. In addition, social capital that must be built in order to effectively move through the
space. I started with patients, moving to physicians once I recognized that in order to help patients, I would need to listen to/hear, involve, and work directly with physicians to create a successful intervention. Other key actors emerged over time as the intervention was being built out, including actors in the hospital (e.g., pharmacy, IT, nursing) and actors outside the hospital (e.g., community treatment providers, politicians, and behavioral health funding entities). These were key stakeholders to involve in the intervention, as they all had a role to play with ensuring the interventions viability. For example, if pharmacy was not trained and integrated at the right time into the intervention, a patient may not get their medication at the point of pathway activation. Or if community treatment providers were not engaged with to create a partnership before the start of the intervention, there would be nowhere to send the patients after discharge, which was a chief problem before the pathway existed. In this project and others, there are key actors (e.g., patients, physicians) who will take the center focus, but there will also be critical key actors that provide supportive roles in ensuring that the intervention being built is ultimately successful.

What documents and policies need to be reviewed?

At the beginning of the planning stage for the intervention, policies, legislation, and current laws/statutes around providing addiction care in a hospital space all had to be reviewed. Many physicians believed that it would be illegal to provide MOUD without a special waiver, and we found it helpful to have a hospital-based lawyer review the statutes to ensure we could build this intervention successfully. Though the legal review came in handy to show physicians to allay fears, it was important to understand where those fears came from
(essentially physicians were worried about losing their medical license). This is an example of ethnographically informed intervention, where the root of an issue is uncovered ethnographically, to which a successful intervention can then be planned accordingly. As we moved further into intervention planning and implementation, other key documents became important to review as well. In working with community treatment partners, for example, state statutes on addiction treatment were important to be familiar with in order to tweak downstream care delivery. The Department of Children and Families 65D-30 statute became our reference bible.

For example, we thought we had successfully enrolled a patient into the BRIDGE pathway, though several days later during the weekly call with the community treatment partner, we informed them that the patient had called the Peer earlier that morning to say they had been turned away at the front desk. When asked why this happened, 65D-30\textsuperscript{44} was cited with no follow-up information offered. But I knew these stakeholders. We had worked together closely for three years at this point, and they were incredibly invested in finding novel solutions to patient care, so where was this resistance coming from? Participant observation and interviews revealed that the community treatment provider was experiencing the same fears as the physicians, as any rules of the 65D-30 statutes broken can result in a center losing their treatment license. It was in this ethnographically informed way that we were able to move towards crafting a solution together because we understood where the concern was coming from, and that provided a starting point to resolve the issue, much like the legal consult for the physicians.

\textsuperscript{44} 65D-30 refers to the rulemaking authority and Florida legislative codes for providing substance use treatment,
How the community needs to be involved

A successful ED-based intervention for a structurally vulnerable population has to include how patients are going to receive treatment once they are discharged. An issue I have observed in emergency medicine is a lack of knowledge about local post-ED treatment availability and how it functions. Often, this is the job of social work or case management, but hospital and community turnover can make staying current with resources difficult. A main goal then of an applied intervention is bridging a patient from the ED (where there is typically not an acute resolution to a social illness,) to community-based treatment where patients can also access much needed structural supports (such as help with housing, food access, bill payment, childcare, or other supports) in addition to medical management. This bridging of care also diffuses potential difficulties in the acute space, where disease is something to be cured, and illness is something that needs to be managed [but not in the ED] (Kleinman 1980; 1981). If there is a clear path forward for both patients and providers, it can mitigate the mismatch of expectations I observed during the ED encounter where both parties are expecting the other to do something productive, but nothing productive occurs, leading to frustration.

The insights about the challenges patients face after they walk out of the ED, gained during my MA research, coupled with my own lived experiences, afforded me the ability to see the world in a different way. Further, anthropological frameworks such as Critical Medical Anthropology (CMA), Clinically Applied Anthropology, and Illness/Addiction Trajectories, brought fresh perspectives to a pressing emergency medicine issue, allowing for the creation of an applied intervention that blended anthropology and medicine into a novel care pathway for a hidden and marginalized patient population. Working alongside physicians was not a fluid
process. I had to consider my own trajectory in tandem with all the other paths I was tracing, and how it all fit together. For example, in the beginning of my master’s thesis project (2016), which was my first time working in a hospital or clinical space outside of a methadone clinic, ardent patient advocacy was my sole focus. However, once I began to spend time in the ED space and observe the reality of providing care for opioid related emergencies, I realized that if I were to keep on this patient advocacy only path, it would be to the detriment of my relationships with clinical staff.

Simply put, in the beginning I did not have a good understanding of the lived realities of providing clinical care in an acute setting, and the toolkit of ethnographic research allowed me to learn and understand much more about patients and physicians and what I needed to know in order to build a successful intervention. Without this ethnographically informed care approach, a critical understanding of physicians and clinical care teams would be missing from the intervention I built, leaving that intervention one-sided and most likely ineffectual. Here is where applying anthropology is vital—no amount of theorizing or studying would have prepared me for the clinical realities of trying to provide OUD care. In addition, thinking about how addiction care as a non-linear trajectory intersects with multiple other non-linear trajectories (e.g., physicians, treatment, healthcare systems, etc.), produced a more nuanced understanding of the in-between spaces. It is this in-between, the liminal spaces between actors and systems, where change can happen (Taylor-Alexander 2015; Vest 2020). It is within the tensions of the liminal spaces of patients and providers seeking and giving care for addiction that the BRIDGE pathway was born.
Chapter Seven

Discussion and Conclusion: From Anthropology of Medicine to Anthropology in Medicine

This chapter considers how anthropology can be integrated into clinical spaces through research, clinical education, and treatment pathway creation for marginalized disease states often permeated by social and structural inequalities. I begin with a discussion of observed gaps in understanding for OUD both in and out of clinical spaces that this study aims to address. I then discuss the value of what is termed here, “trajectory work,” utilizing participant observation, and both extended and short bursts of ‘mini’ ethnography in clinical spaces with an addiction trajectories framework to piece together multiple knowledge and experiential streams. This trajectory work points to a practical, applied approach for studying experience in medicine with a particular focus on drawing connections between physicians’ and patients’ experiences beyond clinical spaces and within them. Following this, I discuss the importance of collecting both qualitative and quantitative data using the medication for opioid use disorder (MOUD) BRIDGE pathway development, implementation, and evaluation that I co-directed, as well as key contributions of this dissertation to theoretical frameworks and applied interventions in medical anthropology; utilizing a trajectory framework for integrating a patient-centered, trauma-informed care model into emergency medicine and mitigating learned helplessness as experienced and practiced by acute care providers.

The next section deals with the challenges and limitations in conducting qualitative research in clinical spaces, and the ethics of sensitive research. The chapter concludes with a
look at historical anthropological attitudes towards and critiques of clinical spaces, how those attitudes are shifting, and the prospect of anthropology working in tandem with the current ethnomedical system (biomedicine). This in tandem work with a focus on the liminal spaces between trajectories has the potential to humanize clinical experiences for patients experiencing OUD. This humanization occurs by integrating key anthropological considerations, such as suffering (Singer 2006), structural violence (Farmer et al. 2006), stigma (Adams and Volkow 2020) syndemics and assemblages of care (Singer and Mendenhall 2017), and the social and structural determinants of health (Woolf and Braveman 2011) into the clinical encounter. Further, as many of these key considerations are either missing or underrepresented in current medical education, this novel pairing of anthropologists and physicians can provide the catalyst necessary to alter the trajectory of clinical education and co-create solutions to pressing health problems in medicine. Finally, I discuss future directions for moving from an anthropology of medicine to anthropology in medicine.

Gaps this dissertation aims to address: Learned Helplessness and Ethnographically-Informed Care

Until “post-colonialism moved the anthropological focus” from an outward gaze to an inward one, there was “little recorded interest by anthropology of hospitals and other clinical spaces” (Long et al. 2008: 71). Social scientists in the clinical space before this point were “mainly sociologists focusing on structural and organizational aspects of hospitals as institutional systems” (Parsons 1951; Freidson 1970; Long et al. 2008: 71). Some of the most important studies of hospitals, however, have been done by anthropologists (Foster 1978:164).
For example, one of the earliest behavioral science studies of nursing was done by an anthropologist in 1936 (Singer and Erickson 2015: 22). Conducting ethnographic research in hospitals and clinics, particularly teaching hospitals or federally qualified health centers that function as safety net for the most vulnerable, can serve as a point of access for working with marginalized populations, especially in groups where access may otherwise be difficult (e.g., insular subculture of drug users). Anthropological inquiry in clinical spaces can be difficult, however, as the reciprocal rapport necessary for access is "a delicate relationship requiring much sensitive nurturing" (Long et al. 2008: 72).

To understand the complex processes of health and illness more fully, from the perspective of what it means to seek care in a clinical setting, anthropology has turned its attention "from local communities and the individuals and households that comprise them, to their health providers, primarily health clinics, as well as surgeons, hospitals, training institutions, and boardrooms" (Manderson et al. 2016: 6). Numerous anthropologists now work in organized systems of health care at multiple levels, and with a range of stakeholders (Deitrik, Capuano, and Salas-Lopez 2010). Much of the work of contemporary medical anthropology focuses on the lives of health care workers, patients, hospitals, clinics, and health-related non-governmental organizations" (Lock and Nguyen 2010). There is also a rich body of anthropological scholarship dedicated to the study of patient care, and how that care is understood, delivered, and received in a clinical space (Baer et al 1989; Rylko-Bauer and Farmer 2002; Patryna 2009; Garcia 2010; Singer 2011; Benton 2015; Sue 2020).

Though anthropologists have been at the forefront of efforts to understand disease as a biocultural phenomenon, the impacts of culture on sickness and health, and the complexities of
how culture and disease intersect, it is not clear that the clinical integration of social theory has been fully realized (Hanson 2017). This dissertation has hopefully demonstrated that adding anthropological approaches, such as the trajectory framework that guided this study, and an ethnographically-informed applied intervention such as a post-emergency visit pathway for OUD recovery in emergency medicine can be a “valuable starting point” for health interventions with the goal of a more serious incorporation of broader structural forces into clinical practice; a causal metric that holds as much weight as disease etiology in diagnosis and treatment (Krumeich et al. 2001).

Put another way, “by understanding what people are experiencing in everyday life, we dramatically strengthen our ability to help” (Mason et al. 2020: 2). Connolly (2001) asserts that the “value of first person, firsthand, insider accounts are the touchstone of phenomenological work” making the mundane a critical site for meaning (Connolly 2001: 178). Additionally, prioritizing lived experience with the utilization of a trajectory framework allows for a deeper anthropological integration with biomedicine as equals, to create treatment interventions that sees the patient become “the expert [of their body] with unique perspectives and valuable insights into their physical state, functioning status, and quality of life” (Roter and Hall 2006: 9).

For example, in chapter five, consider the woman who was still actively using, but desperately needed to hang on to the job she just started. Before the BRIDGE there would not have been any solutions for a patient that was still actively using. After, she was able to remain the expert in her body (e.g., drug use and withdrawal symptoms), and have the space to disclose to the physician what she needed for that moment of crisis in her life, irrespective of if her drug use ceased or not. The treatment she received that day in the ED was “enough to give
her an opportunity to add one more building block to getting into recovery, and that was enough.” This situation highlights the fact that although patients’ “perspectives and experiential responses are subjective, specifically within the context of addiction, which is normally outside of the objective lens that medicine operates within” these experiences constitute ‘an important level for understanding patient healthcare issues’ (Baer, Singer and Susser 2003; Cleary 2003; Mulemi 2008: 118).

Zakkar (2019) reveals that while the patient experience is a complex multidimensional phenomenon with fluid boundaries, health policy makers have also not given enough attention to the impact of a patient’s lived experience of illness and proposes a system (such as those highlighted in this study) which differentiates “the determinants and manifestations of the patients’ experience” (Zakkar 2019: 143). A lived experience approach utilizing trajectory work acknowledges that both providers and patients “possess essential knowledge and important skills [in reference to bodies] and that long-standing power imbalances need to be eliminated” (Gavin 2019). A model of lived experience which emphasizes person-centered, ethnographically-informed care could also help legitimize and promote the role of patients in managing their own care, as well as aiding physicians in the delivery of that care.

Studies that integrate quantitative data as well as qualitative approaches utilizing traditional ethnographic methods aimed at improving the clinical encounter can also add insight into both patient and provider challenges that limit success of current medical models that rely heavily on quantitative metrics to measure success. For example, ethnography ‘reveals people’s cultural realities as they are actually lived’ and understanding those cultural realities ‘in all of their complexity and within their social, political, and economic context ... is crucial to
achieving health equity’ (Mason et al. 2020: 3). This dissertation aims to illustrate how an ethnographically-informed applied intervention can consider factors including culture, structure, identity, subculture, and social illness, and the impacts these things have on sickness and integrate that knowledge into an effective treatment strategy the patient is more likely to consistently follow, without adding another demand to the limited amount of time physicians have available to interact with patients. In order to grow past targeted interventions to systemic change, future work should also consider the implementation of ethnography (Weinstein and Ventres 2001; Kleinman and Benson 2006) into patient consultation, and the development of multidisciplinary research programs and medical training and education which integrate the lived experience of patients as valuable information relevant to patient engagement and treatment.

**Trajectory Work and Ethnographically-Informed Care: Integrating Anthropology into the Clinical Space**

A trajectory framework is a novel way to translate lived experience into clinical relevancy. By first learning about the dynamics of opioid addiction as experiences by patients during my master’s research (Figure 6.20), this led me to engaging with physicians to understand gaps in knowledge in providing OUD care (Table 4.10), which allowed me to create an applied intervention (Figure 5.8) with both physician and patients as stakeholders. I accomplished this by tracing the non-linear trajectories of both groups across space and time to understand what I was seeing during an ED encounter. This enhanced understanding of multiple lives lived and how they converge at a single point in time has the potential to blur the
false dichotomy between disease and illness, merging the two into one cohesive treatment model that compassionately addresses the biological and social complications of drug addiction. Ethnographic research in a clinical space on the contours of addiction using this framework has the potential to create “a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application” (Kleinman and Eisenberg 1978: 251). Integrating this framing—e.g., a focus on knowledge gained by experience as clinically relevant to the treatment of addiction, could facilitate a removal of the barriers often witnessed between providers and drug users during the clinical encounter.

Ethnography in the clinical space also allows for the addition of nuance and complexity in hidden populations of patients (like drug users), whereas otherwise drug using individuals may be relegated to a data point or statistic. An open and shut case of pain management referral or drug seeking discharge before any true engagement is achieved between a patient and provider. Here, a blending of anthropological methodology with biomedical caregiving has the chance to create a deeper understanding of social pathologies (Colson and Selby 1974: 253). This deeper understanding could help unravel worries physicians are confronted with when providing care to drug using patients, such as physician fear of deception, “legitimacy” of patient requests, fears of being manipulated into inappropriate prescribing, and previous negative experiences with drug using patients (O Merrill et al. 2002: 331). In the following sections, I will discuss each trajectory outcome, as well as how they can coalesce into a model of lived experience of addiction into the treatment of OUD in acute care spaces.
Ground Zero: Knowledge and Perceptions Trajectory

The knowledge and perceptions trajectory was critical to uncover exactly what providers and patients formally knew about addiction, which in turn informed what they thought they knew about each other during the clinical encounter. You can’t build a house on a bad foundation, so uncovering what gaps existed in the formal knowledge that colors addiction perceptions was vital. For example, if physicians received little formal education around how addiction functions physiologically, there would be poor understanding around the physical process of tolerance, dependence, and withdrawal. This poor understanding would often lead to a negative ED encounter, where the patient is extremely sick and seeking care, but the provider sees no acute illness to provide care for. Perhaps the provider has a painful history with substance use that they have blocked out, but that past bleeds through unintentionally into their patient care from their subconscious, and results in OUD patients receiving a degraded level of care. Or a patient learns from their court-appointed drug counselor that the severe trauma they experienced as a child was just an excuse to get high, and they would get “clean” when they were ready to stop making excuses. Here, the patient would not understand the role trauma played in their OUD, a potential mental health diagnosis like complex post-traumatic stress disorder (C-PTSD) may be missed, and an outsized sense of personal failure regarding drug use leading to greater symptoms of depression and anxiety, which in turn leads to more drug use as a means to self-medicate. In addition to knowledge and perceptions, it was also important to consider substances themselves, as this was often the centering trajectory that brought providers and patients together in the first place.
The Tie that Binds: Therapeutic Trajectory

The therapeutic trajectory included both licit and illicit forms of opioids or opioid replacement therapy (MOUD), as well as adjunctive medications used to treat the symptoms of OUD-related complications. These medications often formed the core of the acute care encounter, where patients came to the ED to somehow get better, and physicians tried to treat the symptoms they were seeing in front of them. There were several key complications around medications in this study from providers and patients that a trajectory framework uncovered. For physicians, tracing their training and formal education on addiction uncovered significant gaps in understanding of available therapies, or how those therapies functioned. For example, patients would often not receive MOUD during an ED encounter before the BRIDGE because it ‘wasn’t the physician’s job to get the patient high’, or ‘the ED wasn’t where you get your methadone, you can get that at the addiction treatment facility’. A lack of understanding around how MOUD functioned in resolving the acute symptomatology of OUD withdrawal, or the fact that OUD is a disease that may need chronic management directly contributed to this poor outcome.

There was confusion for patients around MOUD as well. Say a patient hears from a mentor or drug treatment counselor that MOUD is just replacing one drug for another, and that they wouldn’t ‘really be clean’ if they took it. Or say the patient didn’t understand how MOUD works when they take it, and they took it on their own without medical supervision and accidentally made themselves sick, so now they think they are allergic to the medication. These examples would usually result in a patient denying a life-saving therapy for OUD, that would help them manage their recovery process. With the implementation of the BRIDGE, and the integration of
Peers, these sorts of misconceptions and misunderstandings around MOUD were able to be resolved, resulting in a significant increase in positive patient outcomes.

A Biomedical Anthropological Fusion: Experiential Trajectory

To me, the experiential trajectory was perhaps the most vital, and most difficult to navigate, of the three trajectories. It’s fairly simple to fill in gaps in formal knowledge once they are identified. Knock together a PowerPoint for providers or sit down to have an intimate conversation with a patient, and before you know it you’re plugging gaps and correcting misinformation. Likewise, therapeutic trajectories were relatively easy to trace, the medicine is the medicine. Pharmacologically it was simple to fill in gaps in knowledge, and the BRIDGE provided greater access to care by including MOUD. I often heard during my time in the ED that the medicine is easy, it’s the patient care that is messy and complicated. My qualitative data showed that the process of OUD patient care tended to be messy for both the provider trying to give care, and the patient who was seeking it. In analyzing patient encounters that went sideways, nine times out of ten the “messiness” of poor patient encounters, especially after the BRIDGE was implemented, had to do with visceral lived experiences and a clash of expectations, that informed how providers and patients saw the world. I put a great deal of thought into how these visceral experiences colored the worlds of patients and providers, and for me, the answer is humanizing the experience of addiction for physicians, which then changes the dynamic of interactions between patients and physicians; while at the same time letting patients know they are understood and will get the support they actually need, and not dismissed outright as “unfixable.”
Every patient engaged in the BRIDGE pathway was what is often referred to in the literature as “structurally vulnerable” in some way, and nearly every conversation I had with a clinician who had an outsized negative reaction to OUD patients revealed a painful past with substances, most often involving a close family member in their childhood. Take, for instance, a case manager who kept denying patients a four dollar bus pass for no apparent reason—an abusive, alcoholic father. I just couldn’t figure out why they had a pattern of this approach. That individual said, “I don’t have time to be giving out bus passes or turkey sandwiches, I have real patients to see.” Some variation of the phrase ‘we’re not here to just give out bus passes and turkey sandwiches’ is often used in the ED to refer to structurally vulnerable patients who come seeking care for something other than an emergency. Once I heard this phrase enough I began to understand that it functions to other patients who aren’t seen as legitimate, and also to express frustration around a lack of acute treatment options for this population. This is explored further below. Or a physician who would leave OUD patients to the resident physician to see, and the plan of care was always a short observation and discharge—a sibling who had overdosed and passed away. “They don’t belong in the ED, if they wanted to stop using they would, so they can go do that on their own time.” Even for physicians who did not have a personal history related to addiction, the micro-traumas of seeing this patient population day in and day out with no training on addiction and no viable treatment to offer will eventually wear someone down into a severe state of burnout towards OUD patients, resulting in poor care.

For patients, the “So, how did all this get started for you” section in chapter four describes the ways every single patient I asked this question to situate their drug use in their childhood around structural vulnerability, whether they realized it or not. By this I mean
incarcerated parents, family overdoses, childhood abandonment and abuse—I did not talk to a single patient who did not have multiple such family dynamics in their past. Often, these issues were both multi-and-intergenerational, which directly affects substance use as patients age into adolescence and adulthood. When painful past issues are triggered during an acute encounter, it can feel like live wires are being sparked together, and it is very difficult to reason in this state for either the patient or the physician. Further, a lack of clear understanding around why either person is reacting the way they are, or how severely their prior life experiences have affected them, and the ED encounter can devolve into an explosive situation. I believe a way to circumvent this explosion, which is for me reflective of how the three trajectories coalesce, is to integrate person-centered, ethnographically-informed care into the ED encounter through clinical treatment pathways like the BRIDGE. I describe this in more detail in the next section.

When Trajectories Combine: Patient-Centered, Ethnographically-Informed Care

This study has highlighted the roles that social and structural inequality play in the development of OUD, however it can be difficult (if not impossible) to effectively address these inequalities during a short ED encounter. Based on the findings of this study and through the process of assessing the BRIDGE pathway, I propose a way to move towards a structurally-informed model of care (Metzl and Hansen 2014) is with the incorporation of a patient-centered, ethnographically-informed approach. Patient-centered care was coined by Edith Balint in 1969 as “understanding the patient as a unique human being” (Balint 1969: 269). Current medical training tends to “focus on the biomedical model and is not co-developed with
patients and health-care providers, despite successful models that incorporate both perspectives in the development and implementation of training [and treatment]” (Santana et al. 2018: 430). The BRIDGE is one such model that has demonstrated this success, by integrating patients and providers in the creation and implementation process. Further, the incorporation of person-first language (see Appendix H), worked to diffuse tense situations at the beginning of the ED visit, resulting in increased positive outcomes and positive patient experiences. Moreover, care that is ethnographically-informed speaks to the heart of structural inequalities, shedding light on the often opaque complexities of addiction for patients and providers.

A commonly employed model that is used in public health and medicine is one called “trauma-informed,” and has some similarities to what I have described as “ethnographically informed.” Below I describe the first approach and then consider how ethnography may overlap in some ways, but diverges in other, important ways, and how this dissertation contributes to uses of ethnographic methods and approaches to improve care pathways. Figure 7.1 shows ‘six guiding principles to a trauma-informed approach’ developed by the Centers for Disease Control’s (CDC) Office of Public Health Preparedness and Response (OPHPR), in collaboration with the Substance Abuse and Mental Health Administration’s (SAMHSA) National Center for trauma Informed Care (NCTIC).
There are six steps to a trauma-informed approach: 1) Safety, 2) Trustworthiness and Transparency; 3) Peer Support; 4) Collaboration and Mutuality; 5) Empowerment Voice and Choice; and 6) Cultural, Historical, and Gender Issues. Learning SAMHSA’s principles and:

“...adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement” (CDC; SAMHSA 2020).

The trauma informed approach is similar to what I refer to as ethnographically informed in the following ways (as exemplified by the BRIDGE program: 1) creating a safe space for physicians to learn and ask questions, as well as creating an atmosphere where patients could feel safe
when vulnerable and in need of care for OUD; 2) Fostering a culture of trustworthiness and transparency by always being present to help physicians and care teams with any part of the BRIDGE process, complete transparency in how we build out the treatment pathway, and providing that same trustworthiness and transparency during the patient care encounter; 3) Creating a Peer-led model, where Peer Recovery Specialists help physicians and patients navigate the linkage to care process for OUD; 4) Engaging in intense collaboration with physician and patient stakeholders, community treatment partners, and behavioral health organizations to ensure the continued mutual benefit of the BRIDGE for all involved; 5) Empowering physicians, patients, and community treatment partners with an equal seat at the table in the care process for OUD, where there was always an open opportunity to voice opinions and make informed care choices; and 6) Educating both physicians and patients on the culture and history of addiction, creating equal opportunities for access to comprehensive care (e.g., pregnant and post-partum mothers), and continuously aligning the vision of the BRIDGE pathway to increase structural competency in emergency medicine care for OUD patients.

Understanding the role structure plays in addiction, e.g., social, political, and economic, is also vital. While Figure 7.2 was developed as a tool for first responders to navigate caring for patients who have suffered a natural disaster, there has not been a clear path for how to integrate these steps directly into an acute space, which the BRIDGE has done by understanding what patient trust, peer support and empowerment look like ethnographically. Moreover, though patients with addiction mirror many of the traumatic symptoms of someone that has experienced a natural disaster, they are instead regarded as ‘deviant’ or ‘non-compliant’. Many ethnographic works in this area aim to problematize social and academic imageries conjured
upon mentioning the urban drug user, comprised of “psychopathology and the sociology of deviance”, however, anthropologists have “often ignored the wider social context that fosters drug use and addiction, a core issue among... medical anthropologists studying drug use” (Singer 2012: 1750).

In clinical spaces, psychopathology and deviance regarding drug using patients is habitually the dominant narrative. Therefore the benefits of conducting a trajectory focused ethnography in tandem with physicians in hospital spaces not only highlighted the value of subjective experience but allowed a deeper integration of formal knowledge on addiction medicine, paired with positive experiences with addiction subculture in the treatment setting. This strategy provides an opportunity to combat the positivist reductionism often found in clinical (particularly acute) settings, as lived experience is highly individualized and cannot be replicated using a scientific model. While quantitative data were collected for this study, which was key to illustrating to a healthcare system how the intervention was ‘successful’, it is the ethnographic data collection and analysis that gets to the heart of these highly individualized experiences that a quantitative assessment alone cannot contextualize. This focus on individual experience [both physician and patient experiences] and how that ties into patient care has the potential for physicians to gain a new fluidity in their practice that would allow for the creation of a mutual social contract during the care experience. This mutual social contract works to equalize the giving and seeking of care process in emergency medicine for hidden populations.
Studying Lived Experience in Clinical Spaces

This study employed a hospital-based ethnography to co-create an applied intervention with physicians and patients as key actors/stakeholders in the space, and an ethnographic approach allowed them to dictate what would be most useful and impactful in that space. While ethnography is a cornerstone anthropological research, there is still significant opportunity to integrate it into clinical spaces. With interventions like the BRIDGE pathway, providers can begin increasing their understanding of structural factors that present roadblocks to successful OUD treatment and tailoring care to individual patients, as not every patient will experience OUD in the same ways. Medicine has become “more technically successful yet paradoxically more criticized... [and has] lost focus on the person and their experience of illness” (Hemmings 2005: 92[emphasis added]). The utilization of ethnographic observation in the ED can offer “rich information and thick description [that would be] ... otherwise not discoverable” during a typical encounter (Goodson and Vassar 2011: 4).

In this study, the utilization of such deep observation was especially advantageous because I “not only want[ed] to know the mental life of somebody else but also their embodied ways of living and experiencing [it]” (Van der Geest and Finkler 2004:1995). Further, the clinical space was an ideal place to contextualize patient experience “…[within] the realities of the ward”, providing a greater clinical understanding than if I were to engage with patients after their ED encounter. This study serves to fill a previously identified gap: the “very little ethnographic research [available] about other interfaces or stakeholders in complex medical contexts, e.g., of those exclusive of the patient, of clinicians and their teams, or other kinds of hospital workers” (Long et al. 73). A deeper understanding of the “complexity of multiple...
perspectives has much to offer both medicine and anthropology” (Long et al. 76). This inclusion of complexity could

“... open [anthropology’s’] eyes and minds to what it means to do fieldwork and to grasp the critical dialogical relations we create with the people we study, regardless of whether we do fieldwork in the mud or on the street (Kapferer 2006) or amongst the blood and the stainless steel of the hospital” (87).

To truly understand patient and provider experiences, especially in determining if the care delivered/received had positive, negative, or no effect on downstream patient outcomes, ethnography that incorporates the addiction trajectories framework proposed here, would inform quantitative metrics, which allows for tracing connections between what patients and providers experience in clinical spaces as well as the importance of how addiction trajectories effect people’s lives both before and after the clinical encounter.

Building/Evaluating Treatment Pathways Utilizing Mixed Methods

Healthcare interventions have specific quantitative metrics that are assigned at the outset of a project, and at the end of the project these metrics determine how effective or ineffective that particular healthcare intervention was. In evaluating the effectiveness of the BRIDGE program, I utilized an anthropological lens by not only analyzing quantitative patient outcomes, but also by ethnographically following physician and patient trajectories of care to assess whether participation in an applied intervention resulted in 1) positive health effects for the patient, 2) an increase of positive ED interactions between physicians and patients, and 3) a shift in strategies of care among emergency physicians administering addiction treatment.
Table 7.1 reflects a typical healthcare outcome related to an intervention (in this case the BRIDGE pathway), common quantitative metrics to ascertain whether the outcome was successful or not, but also a qualitative contextualization of the quantitative metrics.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quantitative</th>
<th>Qualitative</th>
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<tr>
<td>Increase in Positive Patient Health Effects</td>
<td>Number of patients successfully linked to care; Number of OUD Treatments Administered in ED, Number of Patients engaged in care at 90 days; Relative Decrease in Overdose in BRIDGE enrollments</td>
<td>&quot;...you are this delegitimated person who is... you’re not deserving of care [with OUD]. You don’t have a real issue. You shouldn’t be here. Why don’t you just stop? Like all of those, ED narratives. Right? [right]. So...yeah, that day, I came to the hospital]... I heard you have this program I can get on. I’m like, wait a minute. They’re actually showing interest. What are you talking about? You pinch yourself. But it’s not just in the hospital, either. It [being in the BRIDGE] definitely assisted me [after discharge], getting into the MOURT program [here] has definitely [helped]. I mean, in two months since I’ve been residential [treatment], I’ve put on 30 pounds. I’m going to get my daughter back. I feel healthy, for the first time in a long time.&quot;</td>
</tr>
<tr>
<td>Increase in Positive ED Interactions between Patients and Providers</td>
<td>Number of Peer/Patient Engagements, Decrease in AMA in OUD Patients, Decrease in LWBS in OUD Patients</td>
<td>&quot;Oh, these people now? I love them, they’re great. They don’t, they don’t demean me in any kinda way [like other hospitals]. They’re always helpful. They ask me anything, about what I need, you know, they’re great. And that’s different from anywhere. [any other hospital] You don’t find people like that, right? At least I hadn’t. These are people that don’t judge you, you know. I know they don’t... I’m sure they don’t. It feels like [they’re one of us]. It just feels like I’m here [in the ED] for a normal thing.&quot;</td>
</tr>
<tr>
<td>Shift in ED-Based Care Strategies for OUD</td>
<td>Number of Providers with DATA 2000 Waiver; Number of Buprenorphine Dispensed in ED; Number of Buprenorphine Prescriptions, Number of Naloxone Dispensed in ED; Number of Substance Use Evaluations; Number of Harm Reduction Education Documented; Number of Patients Linked to Care</td>
<td>&quot;I wanted to send a quick note to thank you for the work you’re doing. Two patients last night [that] I saw in triage told me they specifically came to [this hospital] for help because they heard from other patients that we could help them. That our hospital was known in the community for treating people with substance use disorder kindly, that we respect and help people like them. Another physician on the shift had one or two other patients for similar reasons as well, and we were able to [activate the BRIDGE pathway] in one sweep to get everyone taken care of. We would’ve had nothing before.&quot;</td>
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Table 7.1 BRIDGE Outcome Evaluation Examples

Analyzing quantitative and qualitative data in concert with each other is so important to achieving a holistic interpretation of the clinical and social relations playing out in those contexts. By allowing individuals to “describe their own reality, we learn how people experience and define their distress differently than researchers, or how an intervention is adapted to specific contexts” (Patton 1990). With this intervention, through interviews, physicians were also allowed to define their own distress, which was directly integrated into the
implementation of the BRIDGE pathway. This integration is a direct example of how ethnographic data informed its development. The mixed methods data collection research design of the study were important, and both quantitative and qualitative data sets actively inform the other.

For example, when we needed to determine what times to provide the most coverage in the ED for patient enrollment, we took the mean time of patient enrollment and worked from an average (in this case 1pm). Qualitatively, we uncovered the why behind that average, which included learning the whole drug seeking and taking process patients would undertake which usually resulted in onset of withdrawal symptoms around 10am-12pm. This allowed us to tailor our approach based on the specific lived realities of BRIDGE patients. Eventually, we would be able to reach out to those patients to re-engage them in care utilizing peer counselors, circumventing an ED visit altogether. Ethnographic insights such as this were key to co-developing an applied clinical intervention as successful as this one has been to date. From a quality improvement standpoint, a lot of translating back and forth happened between qualitative and quantitative data as well so that we could remain fluid in providing patient care, and make necessary amendments to the pathway (e.g., specific workflow for benzodiazepines, or dedicated pathway for home induction). It is within this interdisciplinary, collaborative model that applied anthropology, with a particular focus on addiction trajectories and the value of lived experience, has the most to offer in clinical settings by utilizing care pathways to shift clinical decision making.
Medical Anthropology and Biomedicine: Past Tensions, Present Engagement, and Future Possibility

Medical anthropology as “a subdiscipline [that’s] more attuned to past arguments and achievements might be better equipped for positive future growth” (Sobo 2011:25).

This section aims to tackle the tensions between academic and applied medical anthropology, present methods and theories that scholars are implementing to bridge these gaps, and future possibilities for the role of anthropology in biomedicine. Ortner (1984) followed the winding path anthropology took from Marxism to the political economy of power, practice, and discourse (138), which saw the creation of a “new goal of ethnography and research that was no longer theoretically relevant description but moral critique... which was directed against power, domination, and oppression” (D’Andrade 2000: 222). This critical turn was keenly felt in medical anthropology by the mid-1980’s, and particularly against the regime of positivist biomedicine, that had power, dominion, and oppression in spades. The danger of this sort of critical, moral advocacy, however, is the certainty, “...the sense that every denunciation of oppression is a real achievement (D’Andrade 2000: 227). Konner (1991) notes that “criticism of medicine has become a major academic and publishing industry” but although many issues exist in medicine, such “high-minded criticism with no evidence of sympathy for the doctor’s plight” was counter-productive and actually harmful to medical anthropology’s reputation in biomedicine (81).

Further, empiricism, “whatever its philosophical problems, is still a powerful force”; the real issue with such heavy-handed critique of medicine lies in the fact that “there is no thought
of testing the truth of these ideas [on dominion and oppression]—rather the impetus is to find ethnographic sites to document these truths (D’Andrade 2000: 229). The gravity of this statement necessitates a moment of reflection. A phrase heard numerous times working in a clinical space is “you can’t know something until you know something.” I also echo other scholars in the declaration that medicine is far from perfect but avowing the inevitability of an outcome before conducting research to verify the hypothesis, but rather only seeking out places to validify what, in the researchers’ mind is a foregone conclusion, is bad science. While the “strong wave of critical thought” (Marcus 2005:679) that surged through anthropology beginning in the 1970’s revealed significant failures in the biomedical structure that unquestionably shaped positive change (Morsey 1979; Baer 1982; 1989; Mechanic and Schlesinger 1996; Lock and Scheper-Hughes 1987; Singer 1996; ), the exclusion of physicians and other clinical and biomedical professionals from earlier works to support the co-creation of ethnographic discovery in a “a holistic, systems- oriented, comparative approach” (Sobo 2011: 25) damaged the medical anthropology subfield. The activism and patient advocacy embodied in critical discourses unlocked new spaces for socio-cultural analysis to be sure, though:

“...the patient-advocacy stance of these discourses, as necessary as it was and still is, often leaves little space for complexity and nuance, and may demonize medical/clinical staff in its very valid attempt to understand patient/family experience—[further] research in this terrain is often poorly received by clinicians, who experience it as ‘doctor bashing’” (Long et al. 76).
This contention also lives within the field of anthropology itself, between academic anthropologists who felt working inside biomedicine was “less rigorous than... work of more traditional-minded colleagues, denigrating [anthropologists] to mere “technicians” (Scotch 1963:32; Dressler 2001)” and applied medical anthropologists who were “seeking practical solutions to specific health problems, [where] theory seemed abstract, obstructive, and sometimes even irrelevant (Sobo 2011: 12). There are scholars, however, that are endeavoring to “bridge the divide between an anthropology overfull with hypercritical rhetoric and an anthropology that is so in tune with the biomedical point of view that it actually had been, itself, medicalized” (Sobo 2011: 19-20).

It is an artificial distinction that “there are two branches of medical anthropology: the theoretical, academic based and the practical, clinical based” (Shand 2005:106). Scheper-Hughes (1990: 189) offers a “mediating, third path between the individualizing, meaning-centered discourse of the symbolic, hermeneutic, phenomenological medical anthropologists, on the one hand, and the collectivized, depersonalized, mechanistic abstractions of the medical Marxists, on the other” in the form of a critically applied medical anthropology. A critical approach “pushes the limits of existing academic politesse to ask harder and rarely raised questions“ (Farmer 1998: 101), while applied medical anthropology [strives to make research] useful for clinical or health educational applications, for influencing health policy, or for effecting social justice (Erickson 2003; Rylko-Bauer et al. 2006; Singer and Baer 2007; Singer and Erickson 2011:3), continuing the original premise of improving the publics’ health.

Carole Browner (1999) asserts that medical anthropologists have “much to offer the world of biomedical research” (135) but worries about practitioners “go[ing] native” when
working in clinical spaces by “losing critical distance…by uncritically accept[ing] biomedical illness categories and explanations” (136). This is a valid concern, as critical distance allows the researcher the space to think and reflect critically on how reality and culture are being subjectively shaped, along with acting as an ‘emotional check in’ regarding positionality and how personal preconceptions or partialities could influence the research.

However, a critically applied medical anthropology enables the documentation of “how medical conditions are as much cultural constructs as they are physiological processes” (Browner 1999: 137), the capability to “merge political-economic approaches with a culturally sensitive analysis of human behavior grounded in anthropological methods… characterized by a strongly applied orientation and a devotion to improving population health and promoting health equity” (Witeska-Młynarczyk 2015: 385). Further, a critically applied medical anthropology may bridge divides between social science and medicine in the clinical space, developing a patient-centric structural gaze to both complement and shift the clinical gaze of physicians and medical staff that often becomes hyper-focused on a priori disease states during the patient encounter. Such an approach moves from “pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions” (Metzl and Hansen 2014: 126).

Here medical anthropologists are the vanguard, moving anthropology beyond “dichotomies such as those between ethnomedicine and modern biomedicine, medically defined disease and culturally constructed illness, body and mind, and social and biological anthropology” (Manderson et al. 2016: 7). Biomedicine and public health experts are
“increasingly recognizing the failure of clinical trials type research to answer all questions and solve all ills” (Sobo 2011: 25). Moreover, “patients and related advocacy groups stand to gain most by an increase in clinically useful research” (Ioannidis 2016). This research proposes a way forward that involves researchers moving ethically and reflexively through the clinical space, while also highlighting the value of anthropology to craft solutions to the pressing problems of medicine that may be limited in progress secondary to the predefined structures of the biomedical system (e.g., reimbursement, time pressures to see many patients during clinic, lack of awareness of structural disease, medicolegal concerns of providers). There is much to be gained by anthropological work in clinical settings, including the ability to make key contributions to medical anthropology theory such as the ones demonstrated in this study with the concept of provider learned helplessness and the modification of a trauma-informed approach to create ethnographies of emergency care.

From an Anthropology of Medicine to Anthropology in Medicine

There is a great “depth of insight available when the ethnographer enters the hospital and anthropology is firmly placed in medicine” (Long et al. 2008: 76 emphases original).

A common practice in hospital-based biomedicine is to conduct a ‘morbidity and mortality review’ of a death “which is flagged as a possible systems-based error on the part of the healthcare institution and team” (Sue 2019: 193). The purpose of this review is to prevent future occurrences by providing education, enacting IT or medical record related changes, modifications to medication or surgical procedures, etc. I was witness to one of these reviews in
the beginning of the bridge pathway, where unfortunately someone we enrolled came back the same day in cardiac arrest from an overdose and passed away in the trauma bay. These are exceedingly thorough reviews by multiple actors within the hospital system, aimed at improving both clinical processes and patient care. Now imagine this same sort of in-depth review for every clinical interaction that went south, for every patient that left ‘against medical advice’ without being seen, for every instance where physicians did not account for structural forces in their diagnostic workup and treatment plan. Obviously, the implementation of a review on every single patient encounter is beyond the scope of reality, especially in hospital systems that have thousands of patients encounters a day, but what if a significant portion of adverse outcomes could be offset before they happen? This is a future that has the possibility of being realized by shifting from the anthropological study of medicine to the integration of anthropology in medicine.

Key issues in healthcare such as ‘patient satisfaction, inequity of access to care, and spiraling costs no longer seem amenable to traditionally biomedical solutions’ (Kleinman et al. 1978: 251). To advance health access and equity in the United States, “a cultural shift is needed on a grand scale” (Mason et al. 2020: 2). Hahn (1995) speaks of the urgent need for a shift from medical anthropology to an anthropological medicine, owing largely to the fact that when patients “come from cultural traditions or social classes that differ from the physician, [they may] feel like they are not heard, understood, or responded to” (263). Hahn further clarifies that anthropological medicine would see the role of the physician as “understanding patient conditions and circumstances, the development of etiological and therapeutic knowledge and technique” and effective communication with patients (293). Moreover, the promise of a
deeply embedded hospital ethnography such as this study could reflect upon the broad assortment of concerns faced within extremely complex institutions and may “offer a new and exciting level of data with which to critically synthesize medical anthropology” which would benefit patients and physicians (Long et al. 2008:74). Further, a deeper understanding that knowledge gained by experience (by both patients and providers) as clinically relevant to the treatment of addiction as demonstrated by this research—could also facilitate a removal of the barriers often witnessed between providers and drug users during the clinical encounter.

**Ethnographically Informed Clinical Anthropology**

This study is in many ways similar to a traditional applied anthropology project, in which I worked with a local culture/group/community (patients) and another local culture/group/community (physicians) who were sometimes at odds with each other and sometimes just moved past each other, creating tension and failed expectations (Hewlett and Hewlett 2007; Hodges 2019; Baer et al. 2019; Holbrook et al. 2019; Wilson et al. 2019). One example of this approach is participatory action research (PAR), where anthropology seeks to understand ‘tacit/implicit knowledge and values that may only be revealed through the study of day-to-day practices, behaviors, and discourse over longer timescales” (Vella et al. 2021:526). A PAR approach allows the researcher to move beyond ethnographic representation, to a space where they become ‘researcher and stakeholder’, with an ‘active engagement in decision-making and planning’ for marginalized populations (Bertrand et al. 2019; Forrest 2019). We can see the PAR model being applied in cultural anthropology in relation to the creation of applicable interventions for contextual therapy in familial relationships (Van Der Meirden et al.
2018) or in environmental anthropology by examining the ‘shared and social values of ecosystems’ in relation to conservation (Kenter et al. 2015).

The sort of ‘critical ethnography’ that PAR comprises still has components of traditional anthropological research which considers structural inequalities and power relations, but the key departure is in applying critical anthropological insights to collaborative projects for social change’ (Hemmet 2007: 301). This research diverges from PAR in that it does not “side with” patients, or those perceived to be less powerful, and advocate for change from their perspective, or define research questions in a participatory way with participants. Rather, the study integrates methods from anthropology such as interviews and participant observation to bring a deeper contextual awareness to how ‘knowledge is generated, framed, contested and enacted’ with a focus on structural social inequalities that other a particular population so that ‘values, viewpoints, and experiences’ are altered (Reed et al. 2021: 527 while also focusing attention on actors that may have from the outset seemed to have the most power (physicians) in addition to those who were perceived to have less (patients).

In the clinical space, though prior anthropologists have carried out projects similar to this sort of work (discussed below), there has not been that critical turn toward a specific, collaboratively applied intervention, such as an MOUD pathway program like BRIDGE. In other words, anthropologists have worked around physicians, been physicians, criticized physicians, or critiqued the biomedical system as a whole, but there has not been a collaborative pathway produced by and with physicians, patients, and anthropologists (one of whom is both a physician and anthropologist) to improve patient care. So even though this type of collaborative work has been done in many subfields of anthropology, this dissertation pioneers a co-created
pathway intervention in one clinical medical context over a multi-year time period with demonstrable success. That is not to say that I have not drawn heavily on anthropological work in this area by previous scholars. In the following section I take a deeper dive into several ethnographies previously mentioned in this dissertation that have informed this work, but also point to how my work differs in a new way.

The work described in this dissertation is informed by medical anthropology and takes a micro-scale intervention at the ‘project or local level’ with the goal of directly influencing change on a macro scale grounded in lived reality (Smith 2019). I argue that this differs from the majority of medical anthropology being carried out today, which focus their attention on dominant paradigms including structural violence (Farmer 2006), clinical subjectivity and the medical gaze (Holmes 2013), the racialized distribution of clinical care (Hansen 2018), gender politics (Sue 2019) or colonial power structures (Reyes-Foster 2018). Farmer’s “big system critiques of power and structural violence related to diseases like AIDS and tuberculosis and how they are associated with poverty and inequality were key to linking anthropology to epidemiology, among many other achievements. Similar to my work, structural violence renders patients ‘ethnographically visible’ by linking their pathology to their personal narrative and the larger structures that constrain how and when they get treatment (or not).

Where this work diverges, however, is with how I approach structural violence within ‘the system’ –the system where I worked as a care provider, director of Social Medicine and as an anthropologist. While remaining critical of the biomedical system and community-based addiction treatment systems (which have long replicated racially and economically unequal treatment of patients), I chose to work within those systems and focus on individual key actors
(physicians and patients) in order to co-create a specific clinical intervention to improve the small part of the system I am working in. I think this has in turn had ripple effects of improvement into both the hospital and community systems, such as the BRIDGE becoming hospital policy, or our partner treatment centers removing barriers to care and recentering their treatment approaches to acknowledge the changing landscape of substance use.

Holmes (2013) research in many ways informed the primary concerns of this dissertation, as he asks the question ‘how can ethnography foster public engagement in health issues?’ Holmes attempts to answer this question by focusing on the production of the clinical habitus, subjectivity, and gaze, and the processes through which biomedical trainees learn to perceive and respond to social differences and inequalities. Holmes goes on to say that ethnographers have always had a unique sort of access to marginalized groups, and

“…attended to their on-the-ground lived experiences, illuminating both the local mechanisms by which larger policies or [an] institutions negative impacts health, and the ways that marginalized groups attempt to adapt to and resists unfavorable policies and institutions” (Hansen, Holmes, and Lindeman 2013:117).

In my research, physicians are considered a group of interest, with their own possible vulnerabilities, as well. This novel way to approach the clinical space through a lens of looking for and documenting “learned helplessness”—even among more powerful actors—and linked to their lack of education and training in dealing effectively with OUD, was critical in understanding that not only would patients need to be empowered to seek treatment, and the treatment would need to be built for them to seek and actually find that treatment, but that physicians would also need to be empowered to provide that treatment.
Hansen (2018) focuses on medication equity for opioid use disorder, and the role race plays in addiction treatment disparities. In a study considering the introduction of a new medication to treat addiction [buprenorphine], Hansen

“examined the social and political implications of clinicians’ efforts to establish addiction as a biomedical, rather than moral or social condition, as well as the ways that neurochemical treatments may be re-inscribing hierarchies of ethnicity and race” (Hansen 2018; UCLA 2022).

My work also involves addiction treatment and buprenorphine. But instead of a direct focus on how our current system of addiction treatment reifies and reinforces racial disparity, or the struggle of individual clinicians working in silos to prescribe addiction medication and the social and political backlash of that, I instead focus on one specific clinical space (one ED). Though I found the same structural issues in my field site, this specific focus on one space allowed the above issues to become more manageable and make space for the creation of an ethnographically informed intervention to afford all physicians in the space with the ability to provide this treatment via a formalized clinical treatment pathway. Both approaches are a valuable pairing of micro and macro level forces, and even hinge on the same medication, but look different in their application.

Sue (2019) focused on the intersection of US prison systems, addiction policy, mental health, and drug treatment in her latest research that ethnographically follows a group of women as they cycle in and out of jail and methadone treatment through a lens of structural violence, gender inequality, and ongoing trauma (similar to this research). Building on Hansen’s (2018) work, Sue considers the gendered dimensions of the War on Drugs. With this
ethnography, insights are provided about the ‘experiences of women in these institutions, but also about how society can better support them in their journeys to reclaim dignity and health’ (Pauca 2022). While ethnographies like this are extremely useful for getting that inside look into a person’s life, and how both the system at large and individual processes conjoin to promulgate suffering, there was no specific clinical pathway devised and operationalized that would ease the transition from jail to treatment for these women.

Garcia (2010) examines, through a historical lens, how inequality and violence unfold in myriad social and political spaces. In her research in Mexico, Garcia traced the relationship between ‘colonial history, poverty and intergenerational heroin use in northern New Mexico’ (Stanford 2022). The argument here is that addiction to heroin in this location is a modern visible representation of old problems—including ‘cultural and economic dispossession, social and intimate fragmentation, and the existential desire for a release.’ With this research, I too ethnographically consider poverty, intergenerational drug use, and forms of dispossession—however I leverage these concepts in the clinical space to render structure visible to physicians, often leaning on these concepts to provide clarity around why patients may not have the tools or means to follow medical advice, showing up ‘over and over’ in the ED. This is another example of mobilizing anthropological thought and ethnography as a means to address a pressing social problem (opioid use).

Reyes-Foster (2019) explored the challenges of seeking psychiatric care in Mexico, and how the colonial matrix of power and neoliberal health reform complicates the access and delivery of this care. This is a classic example of employing a critical lens to critique a system of power, utilizing a patient-facing ethnography. Here, the argument is that the ways in which
‘physicians and patients interact with each other is a way to see the physician power functioning in a colonial matrix of power’ (114). I, too, focused on power dynamics present in physicians and patient interactions during the care encounter. Though instead of focusing on neoliberal health policies that complicate health delivery, or a colonial matrix that robs patients of agency, I instead sought to understand the differing cultures and mismatched expectations between the individual actors during the care encounter. It was here that change could be wrought through ethnography, and I consider how that micro change (improving the patient encounter) could morph into macro change (new policy implementation).

While I took pieces of praxis, theory, and wisdom from all research cited above, this research looks different in the next step that it takes after ethnography—by utilizing an ethnographically informed clinical anthropology to create a specific intervention to affect change, here with a unique physician-inclusive framework driven largely by a non-physician. In this study, me ‘talking to doctors’ looked different than other anthropologists ‘talking to doctors’—I recognized that it would not be enough to talk to doctors, I would have to explicitly work with, hear out, and listen to/integrate physicians directly into this intervention, which I believe is what is new/different. Further, this research was also not a large systems attack (e.g., Farmer) or a critique of colonial power imbalances between patients and physicians (e.g., Reyes-Foster), but rather a grassroots effort to operate within a small subset of ‘the system’, working directly with individual actors (physicians, patients) to create an ethnographically-informed treatment intervention.

This largely ‘studying up’ (Nader 1969) approach eventually gave access to top-down solutions as well, such as the BRIDGE pathway becoming official hospital policy. I believe to
date medical anthropology may have done work ‘about’ hospitals or talked ‘at doctors’ standing ‘in’ hospitals or offered critique on large scale forces hard to address with a singular intervention—but have not necessarily been a ‘part of’ the hospital as collaborators, with a key role in decision making and pathway design. Further, to date there is little evidence of medical anthropology studying a doctor’s plight in treating OUD, as well as the patients and considering that during the applied intervention creation, where doctors become a part of and stakeholder to a solution being built. Patients I interviewed during the CMA-based ethnography for my master’s thesis work put the blame on doctors for their poor care, but by moving away from a systems critique focused on stigma, I discovered a learned helplessness in physicians who are also bound by the system I was critiquing, which often puts the power to evoke change surprisingly out of their hands. This key insight led to recognizing the utility of a trajectories model to trace the non-linear movement of multiple actors (not just patients or systems) through space and time, with a focus on how they come together during the ED encounter. This resulted in a need to create a non-binary, more nuanced view of addiction, which created the room to work alongside clinicians/providers. This translational space is what allows for an ethnographically-informed clinical anthropology.

This work was not ‘dictated by biomedicine’ but, instead, engaged in a two-way feedback system in which medical anthropological theory and methods are advanced and utilized directly in a way that develops not only clinical patient care but also anthropological theory itself’ (Wilson and Baer 2022). To Singer’s (1990) point, it may be helpful to view this work along a continuum, where all contributions, whether they be from physician anthropologists or medical anthropologists, are valuable and work towards common goals, but
look different in their praxis and theoretical framing, while making it clear that praxis is not mutually exclusive to theory (Rylko-Bauer et al. 2006).

**Anthropological Findings and Contributions**

This study blended an anthropological trajectory theory (Raikhel and Garriott 2013) and methodology (interviews, participant observation, patient outcomes tracking) in order to create an applied clinical intervention (BRIDGE). Utilizing a trajectory model moves past outmoded binaries and ‘fixed’ views of addiction (e.g., legitimate patient vs drug seeking; choice vs no choice; brain disease vs moral failing) and challenges this long-standing tension in medicine and medical anthropology, where either a pathology/disease model (Vrecko2010; Campbell 2007; Martinez et al. 2007; 2011) or a positive/ritual view of addiction (Douglas 1987; Lende et al. 2006; Satel and Lilienfeld 2014; Snodgrass et al. 2022) is the single-minded solution. By implementing an ethnographically informed applied intervention for the treatment of OUD, many of the binaries of addiction became largely irrelevant to the medical management of acute opioid withdrawal from a physician point of view. This in turn began to dissolve binaries for the patient as well, most saliently the belief of a fixity of addiction (e.g., always be an addict, never recover state of normalcy). This unique, directly applied clinical approach could have only been accomplished utilizing anthropological methods. While other approaches (e.g., CMA) have been valuable in providing understanding around addiction experiences and offered systems critique, these approaches to date have not co-created this type of model that blends theory and praxis in a clinical space, nor have they developed applied interventions (Farmer 2006; Singer 2008; Garcia 2010; Hansen 2018; Sue 2019; Reyes-Foster 2019).
Applied medical anthropology has been carried out in clinical spaces, but limitations around access and power in the space may have made that research limited, or perhaps the questions were just being asked differently as the goal of the research was not applied intervention. Some physician anthropologists pursued this type of work, but their approaches were different. With this research, over a period of five years I was able to act is some sense as an equal with physicians in co-designing the BRIDGE pathway, which provided unique power in the clinical space; however I was not constrained by the actual job of being a physician, and this lack of constraint allowed me to see things differently and maintain a critical distance. This directly applied clinical approach, paired with a trajectories frame and critical distance, is what allowed me to uncover the concept of a ‘fixed trajectory’ and the notion that learned helplessness is applicable to not only patients but physicians as well. This research started as a CMA-driven ethnographic critique of a system of power in relation to OUD (Henderson 2018).

Through utilizing the theoretical framing of physician anthropologists, and addiction anthropology, an applied intervention was crafted with a unique physician-inclusive design which moves the field past common critiques of CMA or patient/advocacy driven ethnography. Key themes uncovered during this dissertation research (Table 4.9) demonstrate that many of the same themes felt by patients were also shared by physicians. In working closely with both groups, I was able to recognize the marked similarities between the two groups, which allowed me to understand more deeply what sort of intervention would be most effective that would take all of these lived experiences into account. A shared experience of helplessness actually existed between the two groups but was previously missed. This process of creating an ethnographically informed applied intervention created a chance to reveal this shared culture.
and recreate it more positively through a new type of interaction. Of particular note, 100% of all patients and providers I interviewed post intervention reported feeling increased empowerment in giving/seeking care for OUD. Other areas of vast improvement include the reduction of stigma, changing attitudes around the ‘fixity’ of addiction, and improving communication during the acute encounter. Utilizing ethnography and participant observation and applying the data uncovered towards a targeted intervention allowed both groups to distinguish similarities in each other, diffuse tension, and improved patient care, increased physician’s ability to provide treatment for OUD, and positively changed healthcare system policy. The following section describes these specific findings from this study.

Finding One: Fixed Trajectory

This research uncovered what I refer to as a ‘fixed trajectory’ which was influencing patient/physician behavior, interactions, and planned interventions/treatment. Although Raikhel and Garriott (2013) argue that there are multiple trajectories of the ‘movement and method’ of addiction which was very influential for this study, their framework did not include an important component, which is a fixed trajectory that emerged from this research. Here, a fixed trajectory is the widely shared assumption that addiction is untreatable, and functions as a scarlet letter in society. This trajectory weaved throughout all other trajectories, together and separately, and impacted care at all levels. I often had to grapple with this fixity before being able to move forward in any meaningful sense with both patients and physicians. However, what is novel about this research is that the BRIDGE demonstrates that emergency care is an
appropriate space to successfully provide both medical and social management of opioid use disorder, disrupting notions of fixity.

**Finding Two: Learned Helplessness**

This research expands the concept of learned helplessness in a novel way to flip the lens of analysis to also consider people in positions of power. By flipping the focus of analysis to include those in positions of power, I illustrate the importance of vulnerabilities at multiple scales of power. Further, I worked to uncover and mitigate frustrated hopelessness in physicians and patients. Here, the concept is useful, but what is more impactful is how this concept can be used in the analysis of positions of power and how that effects systems of care.

The majority of medical anthropological works to date tend to focus on either the institution, the system, or the patient. Here, key consideration is applied to the institution, the system, the patient, and individual key actors [physicians] that wield power in the care continuum but also feel powerless in their own way. This is an anomalous vulnerability to uncover, which was uncovered only due to extended ethnographic work in the space. In this study/applied intervention, it was critical to understand that each of the actors felt powerless to change the unproductive dynamic when giving and seeking care for OUD.

**Finding Three: Physicians as Stakeholder**

A physician inclusive framework and multi-actor perspective of trajectories in different settings over time can serve as an example of studying both up and down, and both inside and outside the clinical space. Studies such as Farmer (2004) or Hansen (2018) of big systems
criques of structural issues are offered by anthropologists who happen to also be physicians, but do not include a physician and anthropologist co-driven solution to address the issues being critiqued. Medical anthropology research, such as Reyes-Foster (2019) or Garcia (2010) tangentially involves physicians in the periphery, becoming more of a stand-in to illustrate structural inequality and the role medicine plays in unequal care distribution, but are never engaged with as collaborators to create an applied intervention to improve patient care. The physician’s voice is not given equal weight to the patient in these works, with each group being considered in their own right as a group that may lack certain powers to effect change, are constrained by knowledge and access gaps, and are burdened in equal measure during an acute care encounter by a system that promulgates structural inequality. This dissertation aims to provide an effective example of what can be possible when all direct actors of the issue you are studying are given equal input, and those actors work together to create an ethnographically-informed clinical intervention to improve patient care.

The Significance of a Bus Ticket and Turkey Sandwich

Several times in this dissertation, I reference turkey sandwiches and bus passes (see chapters four and five). This is actually a common refrain in emergency medicine, a sort of “straw man” argument for why certain people don’t belong in the acute space. It’s an easy phrase to utter in frustration without a real sense of what you are actually saying... “I’m so tired of these people only coming in here for a bus ticket or a turkey sandwich and taking away from real patients who need care.” It is a concept that gets handed down to other clinicians, becoming a part of a particular ED’s culture if not refuted, and everyone from attending
physicians, to residents, to nurses, to medical students start to other structurally vulnerable patients as they say it to one another. There was a particular case manager with whom I got into a heated exchange with one day over a patient. The patient had been enrolled in the BRIDGE the last week, but for whatever reason was not able to make it to the treatment center and was back in the ED for withdrawal. We re-enrolled them into the pathway and reached out to social work to arrange transportation. “They can’t get another bus pass” they said, “they were here six days ago and got a bus pass. We are not here to just hand out bus passes or turkey sandwiches to people.”

I attempted to explain to them why this patient had not been able to pull their lives together enough in the last six days in order to not be structurally vulnerable enough to need a bus pass to a treatment center. But the case manager wasn’t having it, and I ended up paying for the bus pass personally\textsuperscript{45}. I was voicing my frustration to a member of ED leadership, and they agreed—“Oh my God, what does it matter? If it can move them through here quicker, just give them the bus pass. Feed them. Reduce their suffering, so we can move on to the next patient!” they said. And while I do remain frustrated when a person with a steady income and in a position of power begins to other patients, begrudging them a rather unpleasant looking turkey sandwich or a four dollar bus pass, this vignette provides a distinct example of how this ethnography has illustrated the need to break down the binaries of ‘fixed addiction.’ It also re-enforces the reality that there is simply no substitution for experience or exposure. If an anthropologist new to observing the ED space heard this story without any context, they may say “Oh my God! How could you treat patients like that!” But exposure to and ethnography of

\textsuperscript{45} This patient is still in stable recovery today.
the healthcare space and its power dynamics—which includes understanding the lack of power clinical care teams have—provides vitally needed nuance to how this phrase could become a cultural norm. It often involves physicians and nurses being constrained by the same biomedical system as patients.

Based on interview data, physicians generally go into emergency medicine expecting to treat emergencies (not an unfair expectation), but instead treat only limited numbers of emergencies and the majority illnesses related to structural inequalities that are impossible to resolve during a short ED encounter. There is no prescription or procedure for stable housing, for example. So over time, it appears that physician burnout and apathy set in as they see the same patients over and over again, do what the textbooks told them to do over and over again, and over and over again it fails. By providing an applied clinical treatment intervention for OUD, the BRIDGE pathway not only moves us past identifying what the problem is, but also integrates structural competency (Hansen and Holmes 2013) into clinical medicine, allowing for the resolution of not only acute health concerns, but also structural barriers that will still be present after discharge. This hybrid model may offer the most success for addressing complex social disease.

**Policy Recommendations and Future Research Directions**

The final section of this chapter will discuss policy recommendations considered during the course of this research, and how I hope to progress this research both in theory and praxis in the future. In terms of policy recommendations, the most pressing for my state is to review the 65D-30 statutes, which comprises the rules and licensure standards for “Substance Abuse
This set of rules and regulations must be followed to the letter for those who provide treatment services for addiction. When trying to solve patient issues that would come up in weekly calls with the community treatment providers, the 65D-30 statues were quoted almost reverently, as if there could be no alternative answer to the rules found in this manual. With perseverance and creativity, a solution was nearly always found, but it may have been more circuitous and complex than necessary. It is important to note here that the community treatment providers were just as invested as I was about finding solutions to patient issues, but violations of 65D-30 rules could result in the loss of licensure for the treatment agency. In order to continue to create novel applied interventions to address the opioid epidemic, and addiction care in general, it is vital to amend current policies and enact new policies as necessary so addiction treatment is less restrictive. This will allow more people to access treatment and allow those treatments to be varied and tailored for individual experiences.

Future research aims include continuing to develop a translational space between academic and applied anthropology. Both approaches have their own value, but an intermediate space must be created where the two can be fused to create tangible/useful interventions to pressing social problems. This intermediate space may also serve to mitigate a phenomena I have witnessed in the field during my time in graduate school, where we tended to sit around asking ourselves if what we are doing is anthropology, or what it means to be an anthropologist, instead of realizing that anthropology can borrow concepts from psychology, medicine, sociology, etc. but still be a study/intervention crafted by an anthropologist that furthers theory and praxis. Moreover, the experiences of being an anthropologist “in action”

working with a system such as healthcare, can resolve doubts about what an anthropologist ‘should do’ in research. I have learned that it “takes a village” to help patients navigate addiction treatment, and help physicians navigate addiction care, which is why the intervention we have created with the BRIDGE pathway was as interdisciplinary and cross-department at the hospital as possible. Finally, I also plan to continue to develop the theoretical observations in this dissertation, including notions of fixity or a fixed trajectory in addiction research and treatment, and how learned helplessness can be applied to those in positions of power.
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Figure 1A: CDC Program Evaluation Framework
Appendix B: Vector Model of Complexity

![Vector Complexity Model](image)

<table>
<thead>
<tr>
<th>Vector</th>
<th>Sources of increased complexity along the Vector</th>
<th>Specific consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socioeconomics</td>
<td>Lack of health insurance</td>
<td>Difficulty affording treatment</td>
</tr>
<tr>
<td></td>
<td>Lack of transportation</td>
<td>Difficulty accessing providers</td>
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<td></td>
<td>Low educational attainment</td>
<td>Inability to navigate complex systems</td>
</tr>
<tr>
<td>Culture</td>
<td>Race/ethnicity</td>
<td>Care that is not culturally sensitive</td>
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<tr>
<td></td>
<td>Language</td>
<td>Communication barriers</td>
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<td></td>
<td>Communication</td>
<td>Distrust, perceived discrimination</td>
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<tr>
<td>Biology/genetics</td>
<td>Multiple comorbidities</td>
<td>Medication interactions</td>
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<tr>
<td></td>
<td>Genetic variability</td>
<td>Cannot achieve recommended targets</td>
</tr>
<tr>
<td></td>
<td>Cognitive impairment</td>
<td>Inability to follow recommendations</td>
</tr>
<tr>
<td>Environment/ecology</td>
<td>Pollution</td>
<td>Exposure to toxins</td>
</tr>
<tr>
<td></td>
<td>Neighborhood violence</td>
<td>Inability to exercise</td>
</tr>
<tr>
<td></td>
<td>Lack of public transportation</td>
<td>Inability to buy healthy foods</td>
</tr>
<tr>
<td>Behavior</td>
<td>Smoking tobacco</td>
<td>Cardiovascular, pulmonary disease</td>
</tr>
<tr>
<td></td>
<td>Unhealthy diet</td>
<td>Obesity</td>
</tr>
<tr>
<td></td>
<td>Lack of physical activity</td>
<td>Diabetes</td>
</tr>
</tbody>
</table>

*Figure 2A: Vector Complexity Model*
Appendix C: IRB Approval

August 4, 2021

Heather Henderson
501 116th Avenue North
Apt 272
St. Petersburg, FL 33716

Dear Mrs. Heather Henderson:

On 8/3/2021, the IRB reviewed the following protocol:

<table>
<thead>
<tr>
<th>IRB ID:</th>
<th>STUDY002994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Evaluation of Medication for Opioid Use Disorder (MOUD) Pathway in an Emergency Department Setting</td>
</tr>
</tbody>
</table>

The IRB determined that the proposed activity does not constitute research involving human subjects as defined by DHHS and FDA regulations.

IRB review and approval is not required. This determination applies only to the activities described in the IRB submission. If changes are made and there are questions about whether these activities constitute human subjects research, please submit a new application to the IRB for a determination.

While not requiring IRB approval and oversight, your project activities should be conducted in a manner that is consistent with the ethical principles of your profession. If this project is program evaluation or quality improvement, do not refer to the project as research and do not include the assigned IRB ID or IRB contact information in the consent document or any resulting publications or presentations.

Sincerely,

Jennifer Walker
IRB Research Compliance Administrator
Appendix D: Acronyms and Abbreviations

1. 12-Step- Programs like Narcotics Anonymous (NA), Cocaine Anonymous (CA), or Alcoholics Anonymous (AA).
2. ACE- Adverse Childhood Event.
3. ACEP- American College of Emergency Physicians.
4. Addict- An outdated and stigmatizing term used to refer to people with a substance use disorder.
5. AMA- Against medical advice.
7. BRIDGE- Building Recovery Integration into the Gateway of Emergency medicine.
8. Bup/bupe/subs/strips/films- All colloquial terms to refer to buprenorphine.
9. Catching/Caught Charges- Refers to being arrested and being charged with crimes.
10. CBO- Community Based Organization.
11. COWS- Clinical Opioid Withdrawal Scale.
12. Dope- Can mean any drug, but usually refers to heroin, fentanyl, or methamphetamine.
14. Dosing- A colloquial word that refers to taking daily MOUD, usually at a treatment center.
15. Downstream Care- Treatment that is received after discharge from the ED.
16. Dropping- A colloquial word that refers to completing a urine drug screen.
17. Dropping dirty- Refers to a urine drug screen positive for substances. Terms like dirty and clean are no longer appropriate, however. Current terms are reactive or non-reactive.

18. DSM-V- Diagnostic and Statistical Manual of Mental Disorders, Version Five.

19. DT’s/DT’ing- Refers to Delirium Tremens, a serious form of alcohol withdrawal.

20. ED- Emergency Department.

21. EHR- Electronic Health Record.

22. EM- Emergency Medicine.

23. EQUAL- Emergency Quality Network.

24. Fix/Getting a Fix- Refers to using opioids to resolve withdrawal.

25. HCV- Hepatitis C.


27. HIV- Human Immunodeficiency Virus.

28. IDEA- Infectious Disease Elimination Act.

29. LFT- Lost to follow-up, which means a patient no longer engaging in treatment and unable to be reached.

30. LOS- Length of Stay.

31. MAR- Medical Administration Record.

32. Marchman Act- The Hal S. Marchman Alcohol and Other Drug Services Act of 1993, or more commonly referred to as the Marchman Act, provides for emergency assistance and temporary detention for individuals requiring substance use evaluation and treatment in the state of Florida.
33. MI- Motivational Interviewing, a counseling method used to enhance a person’s motivation to change.

34. MOUD- Medication for Opioid Use Disorder.

35. NIDA- National Institutes on Drug Abuse.

36. OUD- Opioid Use Disorder.

37. SDH- Social determinants of health.

38. PCE- Positive Childhood Event.

39. PWID- Person who injects drugs.

40. PWUD- Person who uses drugs.

41. Relapse- A term used when a person begins using drugs again after a period of abstinence.

42. ROSC- Recovery Oriented System of Care.

43. ROI- Request of information.

44. RVU- Refers to relative value unit, which is currently used by Medicare to determine the amount of reimbursement for providers.

45. Shooting/Shooting up- Injecting drugs.

46. Shooting Gallery- Location usually indoors) where people go to inject drugs.

47. Throughput- ED throughput, measured by a patient's length of stay (LOS), includes increments of time between the arrival to and departure from the ED. Reducing an ED's LOS promotes quality care and patient safety and is often used as a key performance indicator for hospital ED’s.
48. Tolerance- Refers to the natural resistance bodies build up with prolonged opioid use, requiring incrementally more opioids to feel the same effects over time.

49. Trap House- Location multiple people go to in order to purchase drugs.

50. Trigger- Something in a person’s life/environment that results in the urge to use drugs.

51. X-Waiver- A special DEA number assigned to physicians that allows them to prescribe buprenorphine.
Appendix E: Clinical Opioid Withdrawal Scale (COWS)

### Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Date and Time <strong>/</strong>/<em><strong>:</strong></em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for this assessment:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resting Pulse Rate: ________ beats/minute</th>
<th>GI Upset: over last 1/2 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>5 multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over past 1/2 hour not accounted for by room temperature or patient activity.</th>
<th>Tremor observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no report of chills or flushing</td>
<td>0 no tremor</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td>4 gross tremor or muscle twitching</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness Observation during assessment</th>
<th>Yawning Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
<td>4 yawning several times/minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupil size</th>
<th>Anxiety or Irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 pupils pinned or normal size for room light</td>
<td>0 none</td>
</tr>
<tr>
<td>1 pupils possibly larger than normal for room light</td>
<td>1 patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2 pupils moderately dilated</td>
<td>2 patient obviously irritable or anxious</td>
</tr>
<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone or Joint aches if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</th>
<th>Gooseflesh skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
<td>5 prominent piloerection</td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Runny nose or tearing Not accounted for by cold symptoms or allergies</th>
<th>Total Score ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>The total score is the sum of all 11 items</td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td>Initials of person</td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td>completing assessment: ________</td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td></td>
</tr>
</tbody>
</table>


*Figure 4A: Clinical Opioid Withdrawal Scale*
**Appendix F: DSM-V Diagnostic Criteria for Opioid Use Disorder**

**DSM-5 Criteria for Diagnosis of Opioid Use Disorder**

**Diagnostic Criteria**
These criteria are not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids are often taken in larger amounts or over a longer period of time than intended.</td>
<td></td>
</tr>
<tr>
<td>There is a persistent desire or unsuccessful efforts to cut down or control opioid use.</td>
<td></td>
</tr>
<tr>
<td>A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.</td>
<td></td>
</tr>
<tr>
<td>Craving, or a strong desire to use opioids.</td>
<td></td>
</tr>
<tr>
<td>Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.</td>
<td></td>
</tr>
<tr>
<td>Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.</td>
<td></td>
</tr>
<tr>
<td>Important social, occupational or recreational activities are given up or reduced because of opioid use.</td>
<td></td>
</tr>
<tr>
<td>Recurrent opioid use in situations in which it is physically hazardous.</td>
<td></td>
</tr>
<tr>
<td>Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.</td>
<td></td>
</tr>
</tbody>
</table>

*Tolerance, as defined by either of the following:*
(a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect
(b) markedly diminished effect with continued use of the same amount of an opioid

*Withdrawal, as manifested by either of the following:*
(a) the characteristic opioid withdrawal syndrome
(b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

**Total Number Boxes Checked: ____________________**

**Severity:** **Mild:** 2-3 symptoms. **Moderate:** 4-5 symptoms. **Severe:** 6 or more symptoms

*Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Washington, DC, American Psychiatric Association page 541. For use outside of IT MATTRs Colorado, please contact ITMATTTRsColorado@ucdenver.edu*

**Figure 5A: DSM-V Diagnostic Criteria for Opioid Use Disorder**
Appendix G: Post-Data Collection Consent Form

Post-Interview Confidentiality Form
Study Title Study #
Post-interview confidentiality form

It is our goal and responsibility to use the information that you have shared responsibly. Now that you have completed the interview, we would like to give you the opportunity to provide us with additional feedback on how you prefer to have your data handled. Please check one of the following statements:

___ You may share the information just as I provided it. No details need to be changed and you may use my real name when using my data in publications or presentations.

___ You may share the information just as I provided it; however, please do not use my real name. I realize that others might identify me based on the data, even though my name will not be used.

___ You may share the information I provided; however, please do not use my real name and please change details that might make me identifiable to others. In particular, it is my wish that the following specific pieces of my data are not shared without first altering the data so as to make me unidentifiable (describe this data in the space below):

______________________________________________________________________________

___ You may contact me if you have any questions about sharing my data with others. The best way to reach me is (provide phone number or email):

Respondent’s signature ___________________________ Date __________________________
Investigator’s signature ___________________________ Date __________________________
Appendix H: Person-First Language and Addiction Treatment

**Words Matter**

Words are powerful... They can contribute to stigma and create barriers to accessing effective treatment

Use person-first language; focus on the person, not the disorder

**When Discussing Opioid or Other Substance Use Disorders...**

**Avoid These Terms:**  
Addict, user, drug abuser, junkie  
Addicted baby  
Opioid abuse or opioid dependence  
Problem  
Habit  
Clean or dirty urine test  
Opioid substitution or replacement therapy  
Relapse  
Treatment failure  
Being clean

**Use These Instead:**  
Person with opioid use disorder or person with opioid addiction, patient  
Baby born with neonatal abstinence syndrome  
Opioid use disorder  
Disease  
Drug addiction  
Negative or positive urine drug test  
Opioid agonist treatment  
Return to use  
Treatment attempt  
Being in remission or recovery

*Figure 6A: Person First Language and Addiction*
Appendix I: BRIDGE Enrollment EHR Notation

I spoke with @NAME@ regarding their substance use. @NAME@ (CONSENT/NOT CONSENT.20866) to treatment via BRIDGE pathway. @NAME@ (IS/IS NOT.22327) appropriate for MOUD at this time. Patient (DID/DID NOT.23171) receive an induction dose of buprenorphine. Patient (DID/DID NOT.23171) receive a prescription for buprenorphine. Patient (DID/DID NOT.23171) receive naloxone prescription to outpatient pharmacy.

@NAME@ [WAS/WAS NOT.21994] referred to ****. Referral form (HAS HAS NOT.18834) been completed.

Patient to follow-up for treatment (Time; follow-up:16724: "within the next 2-5 days.")


Patient referred by ****.

<table>
<thead>
<tr>
<th>COWS SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resting Pulse</strong></td>
</tr>
<tr>
<td><strong>Sweating</strong></td>
</tr>
<tr>
<td><strong>Restlessness</strong></td>
</tr>
<tr>
<td><strong>Pupil Size</strong></td>
</tr>
<tr>
<td><strong>Bone &amp; Joint Aches</strong></td>
</tr>
<tr>
<td><strong>Lacrimation &amp; Rhinorrhea</strong></td>
</tr>
<tr>
<td><strong>GI Upset in Last Hour</strong></td>
</tr>
<tr>
<td><strong>Tremor</strong></td>
</tr>
<tr>
<td><strong>Yawning</strong></td>
</tr>
<tr>
<td><strong>Anxiety &amp; Irritability</strong></td>
</tr>
<tr>
<td><strong>Piloerection</strong></td>
</tr>
</tbody>
</table>

**Score:**
5 - 12 = mild
13 - 24 = moderate
25 - 36 = moderately severe
>36 = severe withdrawal

---

Figure 7A: BRIDGE EHR Notation
Appendix J: Updated BRIDGE Clinical Pathway

Figure 8A: Updated BRIDGE Clinical Pathway
Appendix K: SAGE Social Research Model

Figure 9A: SAGE Social Research Model
Appendix L: Examples of BRIDGE Training Presentations

Acute Care Management of Opioid Use Disorder

HEATHER HENDERSON, MA, CAS

Legal Issues:
An acute care-based holistic approach to improving care of patients with opioid use disorder and opioid overdose while meeting legal and compliance requirements at TGH

Figure 10A: BRIDGE Trainings
Appendix M: Challenges and Limitations of Qualitative Research in Clinical Spaces

One of the first roadblocks a researcher must face in aiming to conduct in-depth qualitative research in a large organization is negotiating and then maintaining access to the field site. Especially when that field site is a level five trauma emergency department. Entering healthcare organizations “can be even more difficult if the research focuses on a sensitive topic” (Okumus et al. 2006). Often, gaining access “involves some combination of strategic planning, hard work, and dumb luck” (Van Maanen and Kolb 1985:11). Biomedical institutions are “dynamic and complex places [where] outsiders are not always welcome... particularly those asking what may be perceived as sensitive and awkward questions” (Okumus et al. 2006: 3). Especially when the questions you are asking are in the hopes of creating or improving a process. There is also the question of value—e.g., if let into this space, how will the research planned bring value (to this organization, clinic, process etc.) Once access has been negotiated by research leaders, hospital administration, clinic managers, grant holders, or the researcher themselves, then comes the concern of remaining in the clinical space, which often hinges on becoming useful as a means of not drawing attention to the otherness of oneself “…[which] might jeopardize continued entry to the research site... possibly necessitating protracted negotiations for access to a new site, difficult to accommodate once research is under way and time deadlines must be met” Lankshear 2000: 60). Access is further complicated if the research includes vulnerable participants.
Research in Vulnerable Populations

Conducting research in vulnerable populations is a special consideration in this study. Here, the term vulnerable is related to “sexual attitudes, preferences, or practices; the use of alcohol, drugs, or other addictive products; illegal conduct; the disclosure of patient records that may lead to social stigmatization or discrimination, or otherwise compromise an individual’s psychological well-being or mental health” (O’Connell 2010: 6). Though researchers need to be exceedingly cautious in studies that involve vulnerable populations (never mind centering on them), working with marginalized groups can provide a greater understanding of the social determinants of health, as “clinicians are undereducated about the lives and concerns of vulnerable populations, including LGBTQI persons, immigrants, prisoners, and families of patients with diseases considered ‘incompatible with life’ (186). Conversely, working directly with participants that are struggling so conspicuously due to structural inequalities that no single researcher can easily resolve can take an incredible emotional toll on the researcher, which is an underexplored challenge of working in clinical spaces.

A lack of emphasis on researcher vulnerability is not uncommon; Kumar and Cavallaro (2014) assert that the design of “sensitive research focuses on ethical requirements and strategies for protecting participants while less attention has been given to the need for researcher protection” (648). Moncur (2013) considers “...the impact which sensitive research can have on researchers’ emotional wellbeing” citing that social scientists in particular “are adept at mitigating risk to participants, [but] discussing and developing the same degree of consideration for [themselves] is lacking” (1888). Micanovic and colleagues (2020) focus on ethnographic research in particular, which is “characterized by immersion, reflexivity, and
rapport [which] can be unpredictable and uncontrollable, producing a wide range of emotional responses” (1). It is also important to recognize when there is a greater than normal emotional risk to researchers in sensitive spaces due to individual life experiences, for example the similar lived experiences I had in my childhood and early years that made me so adept at achieving rapid patient rapport during the ED encounter (Lee-Treweek and Linkogle 2000). Hubbard et al. (2001) outlines the importance of including the emotional wellbeing of researchers in study design, resolving that “unless emotion in research is acknowledged, not only will researchers be left vulnerable, but also our understandings of the social world will remain impoverished” as the emotional reflexivity of the researcher is vital to the research process (137).

The Ethics of Sensitive Research

An important mission of research ethics, either medical or anthropological, is to avoid the exploitation of, to protect, and to do no harm to, research participants.” (Oeye et al. 2007:2304)

There are numerous policies and procedures that comprise the delivery of ethical care in biomedicine. Informed consent, patient confidentiality and the bodily protection of participants are fundamental foci to most clinical settings and are embedded in the social science code of ethics as well (Lee-Treweek and Linkogle 2000). The Health Information and Portability and Accountability Act (HIPAA) of 1996 protects all forms of patient health information, whether electronic, oral, or written, and healthcare providers must follow these rules, “including most doctors, clinics, hospitals, psychologists, chiropractors, nursing homes,
pharmacies, and dentists” (HHS.gov 2020). Once I was given access to the clinical space, I then become bound by HIPAA requirements. Further, training in bioethics was required, which houses the four principles of healthcare ethics that every biomedical researcher must know: autonomy, beneficence, non-maleficence, and justice (Ashcroft et al. 2007).

In terms of personal ethics, the unique status of belonging I was ascribed by both patients and physicians (see chapter 3) led to some challenging situations throughout the research. For example, in A Frantic Consult (chapter four), I was called on by social work to challenge a physician’s care decision. While I may have agreed that the decision was not in the best interests of the patient, it was far outside my scope of practice to dictate to a physician how they care for their patient, though the social worker felt that I could. I was often called on throughout the course of research to complete tasks or make decisions (even by physicians themselves) that were ultimately the physicians call, not mine. Or when a patient told me in confidence that they were supplementing their methadone dosing with buprenorphine strips because they couldn’t get more than 30mg of methadone a day during their inpatient admission and the methadone dose wasn’t working for them due to tolerance issues. I knew that on the one hand the care team needed to know this, as it could significantly affect the patients care, but on the other hand the patient had confided in me because of a shared sense of belonging, and to relate their information to the physician would be breaking that confidence. There also lies a more nuanced ethical consideration in qualitative research outside of consent forms, release of information forms, and the researcher themselves; first and foremost are issue of representation.
The Significance of Representation

The significance of representation is clear. Often, representation equals reality, e.g., who gets to define and select research problems, whose voice are the results written up and analyzed in, and for whom is the research written? In writing up this research crafted on the lived experience of others, a participant’s (often direct) words were “…framed, prompted, and edited by the researcher” which poses numerous risks…of particular concern [in vulnerable populations] including silencing, misrepresenting, and pathologizing some, whilst normalizing others” (Gabriel 2000: 110). Another issue of representation exists in ethics of research access. Bridges (2018) demonstrates one such seemingly innocuous issue of access, where the author [working in a clinic for mostly state insured pregnant women on the grounds of a hospital] admits to curiosity regarding one of her interview participants that she had not heard from in a while. Bridges then reaches over to the nearest computer to pull up the patient’s chart, reading medical notes to see what has happened. Not only is the tragedy that befell the patient read via medical chart notes but is also published in detail in a vignette in the book. Ostensibly without the woman’s permission, as Bridges admits she “never saw the woman again.”

This story was a significant framing for how race and class intersect with unequal access to healthcare, and as such has most likely been read multiple times, and reproduced in written reviews, without an obvious consideration for the ethical implications of becoming a part of a power structure that gives unfettered access to women’s lives via medical record. It is often necessary to critique a system while being a part of the system, however critiquing a system that medicalizes and surveils patients via heavy handed access to their lives, which I was then complicit in, requires a constant acknowledgment of positionality and power. There were
numerous ways I ensured this acknowledgement during this research process. For instance, I never looked at a patient’s chart unless it was necessary for direct patient care. If I wrote chart notes for a patient, I was extremely mindful of word choice as well as how the note might be perceived by others providing the patient care, as chart records follow a patient throughout the course of their life. An applied outcome of this constant mindfulness around patient charting and power dynamics includes a project that I am currently working on with a physician located in Boston, which would take drug use information off the main page of a patient’s chart, so it isn’t the first thing a physician sees when the chart is opened. In addition, we hope to also amend common phrases chosen during charting such as ‘drug abuser’, instead using person-centered language (see appendix H).

During the write-up phase of the dissertation, any vignette I wanted to include about a patient or physician that had the potential to be misconstrued or included candid information, I called/texted/mailed/spoke to the person directly to ask for permission even though I had previously gotten informed consent. There was no guidepost for assessing this information; if I got feeling when I was analyzing the qualitative data that if it were my information, I may not want something included, or I may want the story worded differently, I always made sure to reach out. Sometimes it was fine, and sometimes the person did want to make changes. In addition to the renewed permissions on a case-by-case basis, I would read over the vignette (and vignette edits) with the person, altering certain details or omitting certain private information at the request of the person. I believe methods such as these work to de-centralize the power of the researcher over the final research product, which in turn works to shift research and knowledge production towards being a more inclusive, equitable process.