

Q&A: Training the physicians who will fight resurgent opioid epidemic

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It's hard to believe that addiction psychiatrist Alëna A. Balasanova, MD, is just getting started.

For her work developing and implementing an addiction and psychiatric clinical service at the University of Nebraska Medical Center—just one year after completing her residency training—and for writing the curriculum for clinical rotations for medical students, residents and fellows in addiction psychiatry, Dr. Balasanova was honored in November with the 2020 AMA Foundation Award for Health Education.

Even as daily COVID-19 death tolls break U.S. records, the opioid epidemic appears to be worsening as well. This underscores why the painstaking efforts of physicians such as Dr. Balasanova are all the more critical.

Dr. Balasanova, an active member of the AMA Young Physicians Section, recently spoke with the AMA about her missions to integrate substance-use disorder (SUD) treatment into mainstream medicine, eradicate stigma, and expose residents and fellows to longitudinal treatment for SUD so they can see patients recover and be part of their journey.

AMA: The integration of mental and physical health services—particularly psychiatric and addiction care with primary care—has been a challenge. What do you think are the barriers?

Dr. Balasanova: Historically, substance-use disorders and addiction simply weren't seen as medical problems. People considered it a moral failing, character deficits, or poor willpower. People had all sorts of negative judgments.



Alëna A. Balasanova, MD

Now we have decades of research that demonstrate precisely how addiction is a chronic brain disease that is very treatable. But we need to have the right tools and we—most of all—need to have the right attitude.

Probably the biggest barrier that I have faced is stigma. Stigma is universal and it starts at the top: Stigma on the part of our government and policies around substance use, in organizational leadership and it goes all the way down to individual clinicians. At every single level, there's structural stigma.

Social determinants of health and structural racism, that is a part of it as well, and these individuals are extra stigmatized. I anticipate stigma will continue to be a big barrier moving forward, unless we actively make efforts to change the culture around substance-use disorder care. **AMA:** How do you see that happening?

Dr. Balasanova: One way is through language. There have been many studies that demonstrate that the language that we use to talk about patients with substance-use disorders really matters with regards to stigma and how patients are treated.

When we say “substance abuse” or “addict,” or “alcoholic,” or “clean” or “dirty” urine, it is extremely stigmatizing, pejorative, judgmental, and not clinically operational in any way. It leads to treating patients worse when we hear those words and when we say those words. Not because we actively want to treat them worse, but because of unconscious biases that we all have as humans. So, I have tried to transform the language of addiction with every single trainee and learner that I come across.

Every single student, resident, fellow and colleague with whom I interact on a regular basis receives information on language, receives literature describing why this is important, receives the surgeon general's lexicon on what is appropriate language and what we should be saying. One by one, our goal is to change the minds of individual people with the idea that they will then pay it forward.

On a more global scale, I authored resolutions for the Nebraska Medical Association, which passed unanimously, and subsequently, for the AMA House of Delegates, which also passed unanimously, on changing the language of addiction and making sure that we are leading by example and using clinically accurate terms that are nonstigmatizing, neutral and descriptive, rather than judgmental and pejorative.

I want to empower every single person that might read this interview, that YOU have the power to decrease stigma. Think about what you say before you say it. It has nothing to do with being “politically correct.” And it has everything to do with advancing patient care. I feel so strongly that each and every one of us can do that and I have seen it countless times.

AMA: Tell us about the beginning of your outpatient substance-use disorder treatment clinic.
Dr Balasanova: This was the first clinic specifically geared towards patients with co-occurring SUDs and other psychiatric disorders in the department of psychiatry here at the University of Nebraska.

There were initial challenges for sure. There are technical requirements, because of federal confidentiality laws, so we could not simply use our regular electronic medical record for these patients. We had to build out a special part of the medical record that would share appropriate data, withhold other data. It was complex and required weekly meetings with variety of hospital and health system stakeholders, chief legal counsel, patient privacy officers and other individuals.

Creating that infrastructure allowed us to then be able to see patients in the outpatient setting, create the documentation structure, templates, all of those things that would facilitate learners to come in and utilize these tools to see patients. And so, our outpatient clinic gave rise to an intensive outpatient program, which began shortly thereafter, using a lot of the tools that we had built, and subsequently, we started having trainees.

I had residents in the clinic, so they could experience what I experienced in training—which was working with patients with SUDs and finding it rewarding. Part of the reason why I got so into addiction treatment was because, unlike many trainees, I didn't only see patients at their worst.

I had the opportunity to work with patients over the course of a year to two years, to three years, where I got to see them get better in the outpatient setting. And I got to follow along with them on this journey of recovery, which I thought was amazing. And to be there with someone as they put their life back together and, to help them do that, I think, is one of the most rewarding things we can do as physicians.

I made it my mission to give trainees that same opportunity, so we developed the longitudinal outpatient clinic, which I called LIMSOC—the Longitudinal Integrated Mental health/Substance use Outpatient Clinic—to allow residents to learn how to work with these patients long term and to see them in a different light.

One of my first residents who completed this year-long clinic is now on faculty in my department as well. I'm always so happy to be able to call on him to cover my service when I need to be out. It's rewarding to see the fruits of your labor, and to see somebody embrace these patients, embrace this kind of treatment and be interested in providing it—which is exactly what I want to motivate.

AMA: What are your long-range plans?**Dr. Balasanova:** My long-term vision is to have an addiction recovery center of excellence, and to have comprehensive, integrated treatment that encompasses primary care, specialty care such as infectious diseases, psychiatric care, addiction-specific care and offer psychotherapy as well as pharmacological treatments, all under one roof and integrated in a care team built for the patient's benefit.

That would be the ideal. I think, by building all of the component parts—our outpatient clinic, our intensive outpatient program, our inpatient addiction psychiatry consultation service—and by having all of these pieces in place and really optimizing them, I think we're on our way to eventually integrating all of it someday.

AMA: How has the pandemic affected your practice, and did you have to close down at any time?**Dr. Balasanova:** For outpatient practice, we pivoted to 100% telehealth pretty quickly after the pandemic started. And the entire psychiatry department went to telehealth. We also did our intensive outpatient program via telehealth. Obviously, inpatient hospital consults, those are continuing to be in person. We did not shut down at all.**AMA:** Do you think telehealth is going to continue to be so heavily used after the pandemic ends?**Dr. Balasanova:** It's probably going to become more of a hybrid. The reason for that is part of the substance-use disorders patient population has been disenfranchised in so many ways—with housing, with socioeconomic status, with food security. Many have a difficult time finding secure access to a device and to the internet—individuals staying in homeless shelters, for example. For them, telehealth has resulted in not being able to see their doctor because they're not able to connect on that platform. On the other hand, for patients that do have access to internet, I believe, they will likely continue to use telehealth, because it is more convenient for their schedule, more conducive to their life and they still get to see their doctor face to face on the screen.**AMA:** Do you have patients in like rural Nebraska where broadband access is a problem?**Dr. Balasanova:** There is some telehealth happening in rural Nebraska from our department—not yet from our addiction psychiatry clinic—but through our geriatric psychiatry clinic. This gives access to care for nursing homes in rural Nebraska, which are a little bit better equipped with internet access than an individual's residence might be. It's absolutely a very real problem for much of the rural population. Nebraska is primarily a rural state. Many that live in the west don't have broadband internet access. That's a big problem because we've come up with this creative solution—telehealth—to ensure patients are getting critical health care during a pandemic. For patients to then not have access to that care due to a technical issue is tragic.

AMA: How else has the pandemic and its isolation affected your patients?**Dr. Balasanova:** Our relapse rates have certainly increased substantially. Hospitalizations for medical withdrawal management from alcohol have increased. We've even seen an uptick in liver-transplant evaluation for cirrhosis related to alcohol use. The pandemic has caused so much social isolation and loss of meaning for a lot of patients, because—if they derive meaning from going to work or just doing the things they need to do—they're no longer able to do that.

Concurrent to that, many treatment programs did shut down temporarily as did almost all the mutual aid group meetings, at least in our area. Some then went to telehealth. All the AA and NA meetings were all being conducted virtually. For a lot of patients, that is just not enough. They need that human connection. The social isolation from that, along with a loss of their recovery-support system likely contributed to increased relapse rates. We have seen patients suffer a great deal more over this past year than we had seen before. I 100% believe that has to do with the repercussions of the pandemic.

AMA: How do you do deal with the issue of stigma, judgmental language, and so on, with your medical students and residents? Are they more open, or do they come in with their minds made up?

Dr. Balasanova: Research has found that, upon entering medical school, folks are kind of bright-eyed and bushy-tailed. They're eager to see patients. They don't have preconceived notions. There isn't a lot of stigma. But, as they progress through medical school and subsequently, through residency, attitudes deteriorate and become more negative as somebody trains. This is likely because of encountering individuals at their lowest point—in the emergency room or on the inpatient unit, and not ever getting to encounter people in recovery.

They get this false idea that substance use always means “crisis” and nobody ever gets better. There are senior physicians and teachers who, oftentimes, also help stigmatize. While a trainee may come in with neutral views, if they keep hearing all these negative things from their superiors, they're going to internalize them.

There's this “hidden curriculum” where you want to fit in with your team and so you might just go along with it and then that will become your view, unfortunately. Starting at the beginning of medical school and through every single stage, it's important that we try to indoctrinate our students to the opposite. That these are patients deserving of care like all patients are deserving of care—and that care can be provided by you. It's not rocket science. It doesn't have to be hard and it doesn't have to be scary.

One of the most rewarding parts of what I do is that, after students and trainees end my rotation on the addiction psychiatry consult service, I always ask them: “How do you think it went?”

More often than not, I hear how much they enjoyed working with this patient population. And how they never thought that would be possible, because—while they may not have necessarily had negative views—they certainly didn't have favorable views. And it's rewarding to me that learners leave with positive views. They leave with hope that patients can get better. They leave with hope that treatment is possible, recovery is possible, and that they can play a role in that—which is something beautiful.

AMA: One of the controversies during the Trump administration was its treatment of asylum seekers including several AMA-opposed initiatives that endangered the health of asylum seekers and made it more difficult for individuals to claim asylum in the U.S. Please tell our physician readers about your experience going through the asylum-seeking process.

Dr. Balasanova: I'm ethnically Armenian. But I was born in Azerbaijan, which is the country right next to Armenia. And, at the time, it was all the USSR.

In 1988, there began ethnic cleansing in Azerbaijan to purge the country of non-Azeris—all the Russian people, Armenian people and others. We fled with what we had to Moscow, where my parents knew some relatives who we could stay with.

Then we applied for political asylum to come to the United States. It took three years to get approval. The Soviet Union was collapsing, and the ruble had fallen. It was a dire situation. I have vivid memories of standing in bread lines as a child. Now we look at that like it's something from history books, but I distinctly remember living through that. And so, having gone through that hardship, and then being able to come to the United States for political asylum and have refugee status here, was transformative for me as a young child.

I was an only child, so I had to step up and help my parents who sacrificed everything to bring me here and to give me the freedoms that they never had. We would have been persecuted had we stayed and likely wouldn't be alive today.

I am a product of the public school system in Lincoln, Nebraska, which I'm very proud of, and valedictorian of my high school. Then I was privileged to be able to go to the Johns Hopkins University with a variety of academic scholarships and, subsequently, to Harvard Medical School. I think I was living out the American dream in many ways. Something that I never would have thought possible.

I stayed in Boston for my training at Boston University. And then I came back to Nebraska, the state that took us in back in 1992. And I feel like I owe a lot to this state for taking in my family and for helping us develop a life here and to become American citizens.

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