Anna: *You're listening to Changing Minds: Transformative Talks for Healthcare Improvement. Grab a coffee or tea and join our team as we chat with leaders in the academic detailing space. For more information on academic detailing, visit us at narcad.org.*

Anna: Hello and welcome back to *Changing Minds*. I'm your host, Anna Morgan-Barsamian, the Senior Manager of Training and Education at NaRCAD. Today we're going to do a special flashback episode and revisit the second annual Academic Detailing Summit. The Summit brought our AD community together through innovation, collaboration, and knowledge sharing.

Whether you joined us live at the Summit or you weren't able to make it this year, this episode will bring you some of the key moments from our opening session, the "Leadership Spotlight." We'll hear from two AD experts, Carla Foster and Sarah Popish, in a real-time interview. We'll explore their identities and insights, focusing on the challenges they've experienced, the need for dedicated resources to support clinicians and patients, and the opportunities for our field to embrace inclusion and equity in each step of our program development and implementation.

So grab your coffee, sit back, and join us as we relive this inspiring session from the second annual Academic Detailing Summit. Don't forget you can find resources, slides, and additional recordings on our AD Summit Hub at narcad.org.

Bevin: I am so jazzed to invite you to kick off our first event in the event. It's our "Leadership Spotlight." It is a live interview with two amazingly talented women who, I have to admit, on a personal and professional level, I sweat. I think they are just so cool. So here to join us is Carla Foster and Sarah Popish.

If you don't know their work, I am happy to introduce you. So Carla Foster is an epidemiologist. She's a PI at the New York City Department of Health and Mental Hygiene in the Healthcare Provider Initiatives Unit. She leads the development, implementation, and evaluation of citywide public health detailing campaigns. You've got to check out New York's kits. We will drop that in the chat box at some point during this session. Carla's awesome. She's got a deep commitment to understanding the impact of intersecting biases, racism, breaking down white supremacy culture, and seeing the impact of that culture on collective physical and mental health. She's spoken to our audiences in the past about race, social determinants of health and clinician stigma. She's joining us today to share her experiences and reflections on many things, but mostly how we can look inward, how we consider the power of our own language, how we can encourage clinicians to really honor patients' individual experiences, and work to build truly collaborative partnerships with their patients. So we all look up to Carla here at NaRCAD. We're excited to learn from her today. Quick hello from you, Carla, and then I'll introduce Sarah.

Carla: Hi, and thanks so much for that introduction. It's so wonderful to be here with you all, the NaRCAD team. I think you all are rock stars and absolutely amazing, and I'm looking forward to this. Thanks, Carla.

Bevin: And with Carla is Dr. Sarah Popish. She is incredible. She's a clinical program manager for the VA's academic detailing service. She's been working on AD for the last 13 plus years, and she's led a ton of AD training programs for the VHA. She actually presented at NaRCAD 2023 about the amazing JEDI program, which is an incredibly inspiring, rejuvenating training program to boost morale for detailers. Sarah has such a refreshing series of tapes on what matters in building a sustainable team, strong programming, and she's been seen by her and her team in terms of health disparities that the veteran population are facing, especially the rural veterans, and how she's working with her colleagues to close those gaps. She's an

incredibly dynamic speaker, an inspiring thinker, very much admired by our community, and she also happens to enjoy the show Outlander as much as I do. So without further ado, welcome, Sarah. Good afternoon.

Sarah: Thank you very much. I'm excited to be here. I forgot about our connection about Outlander, but that is a good show.

Bevin: It's a great one, coming to a close. I'm going to have to find something else to do with my life. All right, so we wanted to just share that both Carla and Sarah have nothing to disclose, that Sarah is sharing that the views and opinions that she expresses are as a panel member, not official position of the U.S. government. All right, pardon me. So I'm going to pull out of this deck so that we can see each other's faces and really just dive into this interview. What this is going to look like, those of you who are at the chat box and at the ready, is please go ahead and put any questions in the chat as we go. I'm going to triage those questions like it's a live radio show as we go, so do not hesitate to pop something in the box. You have these two experts held captive for the next little bit. So let's make the most of our time.

While you're thinking about what you want to ask them, I know what I want to ask to kick off. So there was a question at the beginning of our presentation this morning that Anna asked, when you hear the word inclusivity, what do you think of? Sarah, I really want to turn that to you because I know we've spoken in the past about what inclusion means, particularly for your work at the VHA and the sort of sub-populations of veterans that need the most care. So can you speak to us a little bit about what inclusion looks like and should look like at the VHA, in your opinion?

Sarah: So in my opinion, I think when we think about inclusivity, I really go to the treatment of our veterans who struggle with substance use disorder, specifically those who live in rural environments.

About one-third of our veterans live in rural environments and about 53 percent or higher of veterans actually will over their lifetime struggle with a substance use disorder. And one of the areas that I actually am very proud of in the VA is they really focus in on this no wrong door type of mentality. So we have been utilizing our detailers to spread information to our clinicians about the treatment of substance use disorders.

So a veteran, no matter where they go, can get the help that they need. In fact, we just had one of our detailers share to the executive leadership in the VA a hero story in which because she had been talking about the treatment of opioid use disorder for so long, a veteran actually came in to a primary care clinician in a rural clinic and said, I need help. I'm ready.

That clinician had no clue how to start it, but he had her as a lifeline. And through her, they were able to get that veteran the help he needed that day so that that individual did not walk out the door and continue to use or have an overdose, but they were able to get them treatment right where they were at. So when I think about inclusivity, that is one of the things I think about.

The other thing I think about is how we are really focusing a lot of efforts in the VA towards those rural individuals, because we know if you live in a rural area, one, there's more stigma associated with mental health disorders and substance use disorders. And it also, I think, there's less resources. So you may not even have the broadband that you need.

You're not going to have the clinicians that you're going to need. And even on a personal level, it's just completely different. We just moved to a more rural area, and being able to find providers is a lot more difficult to even get in to see them. And we're not in that rural of an area. So I think that is something that we need to work on. And the VA is putting together things like clinical resource hubs.

So if you do not have the capability to actually treat the person in your clinic, you have a resource that they can use. And they make centers where they can go in and use the capabilities, the internet connectivity in these centers. They have people who go out and drive people to their appointments.

And from our academic detailing service, we have a lot of data and resources that highlight the detailers' reach towards rural veterans. So we used to say rural clinicians, but really what we now look at is rural veterans, because sometimes a clinician will also see people in an urban setting and a rural setting. And so what we want to see is through that interaction, what percentage of our population that lives in a rural area is impacted.

And it is something that we build all sorts of resources about, we talk about all the time, because we really want to make sure that our veterans that are in urban centers and in our rural centers are getting the best up-to-date care that we can possibly provide within the VA. And I think that we're making good strides. I really do. But there's always room to improve.

Bevin: That's amazing, Sarah. And I think one thing that really stood out to me about what you just said is this idea of really making sure that clinicians can adapt and be flexible to different patients with different needs from different settings, so that there's more of a sense, there's less of a silo and more of a sense of, OK, what are we doing? How do we pivot when we're dealing with patients who are more rural? What are the types of stigma that they're facing? And with that in mind, there's a great question from Ryan Anderson in Arizona here, who wants to know, have you found that providers are willing to adopt harm reduction practices and talk to patients about harm reduction, which, as we know, comes with its own potential stigma being received by clinicians and how that stigma meets the stigma of a rural space? I'm wondering what you would want to share in reaction to that question.

Sarah: So we're not there yet. It is growing. It is actually one of our national campaigns. We have a whole bunch of information on harm reduction practices. I know that our detailers actively talk about harm reduction all the time. I mean, when it comes to utilizing overdose techniques like Narcan, we dispense a lot of that.

But there's other things that there is a lot of stigma about. And actively, we have many programs that focus in on this, and they're continuing to push forward. Obviously, sometimes because we are a national entity, we are very limited in some states. There's only so much you can do because it's still against the law. And we cannot break state laws in some instances. But I think that we are making great progress.

And I do believe in a lot of ways it is our academic detailers who are actually leading that push as they continue to talk about the importance of treating substance use disorders and obviously engaging in a harm reduction.

Bevin: That's excellent. And I think the important thing there is to hit on, we're not there yet, but we're moving forward. And the idea of detailers leading that charge, those of you who join us for the whole of the next few days, we'll see just a plethora of feedback from interventions, AD interventions around academic detailing for harm reduction that has been truly sensational and moving things forward in the past year in particular. So thank you,

Sarah, for speaking to that. Want to welcome Carla and say that we can kick off asking you a first question. Similar to Sarah, when you think about inclusivity, what is the first thing you think of in terms of the gaps that exist for patients in the New York area? And a bit from you, I would love you to share some of the really great stuff you've shared with us around opportunities to close some of those gaps, especially with the power of language. So if you can speak to any of that, that would be terrific.

Carla: Yeah. I think that a major gap and really a foundational barrier to health equity is that our current healthcare system really focuses on treating the symptoms or the outcomes of disease as opposed to addressing root causes. And this is really a reactionary approach, and it neglects societal factors and environmental influences that really drive a lot of these health issues. And to truly improve patient outcomes, healthcare needs to shift towards an understanding or intervening on the why behind some of these poor health outcomes.

So asking what are the originating factors that gave rise to this health outcome? In fact, in one of our focus groups that we conducted last year, a large proportion of the community members present expressed frustration with healthcare being this sort of band-aid as opposed to a root cause or preventative care focus. So this is not something that is going unnoticed. And I think in order to achieve an effective paradigm shift, it's going to take looking at the whole patient, looking at their story, their environment, their unique situation.

And by focusing on some of the origin factors, I think healthcare providers are really able to develop treatment plans that are more sustainable and tailored to that person. And this allows us to address not only immediate health concerns, but would also help to empower patients to make informed decisions and to be able to take an active role in their own well-being. And building trust and understanding the difference between trust and trustworthiness, I think is something that's also really crucial.

Healthcare systems should focus on being trustworthy by demonstrating transparency, compassion, and competence as opposed to simply demanding trust from a population, especially a population that has been marginalized. And I want to pull up or read a quote from our health commissioner, Dr. Vassan. We just started a new initiative to extend life expectancy in New York City to 83 years by 2030.

And he states that this plan starts with one fundamental truth that we all have to accept. Healthcare, while critical, is only part of the solution. Most estimates suggest that clinical care contributes only about 10 to 20 percent to overall health. Most of the rest is attributable to social, economic, environmental, and behavioral factors. So, it's time we recognize and invest a proportional amount on prevention. I think that really goes to the importance of being able to figure out what is really going on that drives some of these health issues and being able to impact change there.

Bevin: That's incredible, Carla. I would love if you have a moment to drop that nugget in the chat box and, you know, the link to it because I know I'm going to want to dig into it. And if I know the rest of our community, they're going to want to dig into it, too. But I love what you had to say, too, about the difference between saying you're trustworthy and then demonstrating your ability to be trustworthy through transparency. Can you give me an example of what that might look like? And I gather it's not going to be one act that makes the marginalized group say, okay, I'm going to trust a very, you know, white-run healthcare system that has not made it particularly safe for me in the past. But can you give an example of one step in the right direction?

Carla: Yeah, I think that's really important to point out. And I think it's also important to acknowledge that a lot of feelings about whether or not trust should be given or is warranted is based upon people's very recent or very current experiences with the healthcare system. It's not, you know, it could be partially based on things that have happened historically, but most often in most cases, it's people who have current and very recent experiences not feeling like they can trust the people who are charged with providing them care. So, like you said, one of the things I think that is important is overall diversity, making sure that patients have the ability to connect with healthcare professionals that have similar backgrounds and experiences.

We do see that in particular for patients that are racialized as black, they have better health outcomes when their healthcare provider is also racialized as black. It doesn't hold true for patients racialized as white. They tend to receive, they tend to have the same or very similar health outcomes.

And I think it holds true for people who are racialized as Asian as well. But I think in terms of being able to, on a population level, be able to establish trustworthiness is making sure that the interactions that you have with a population are trustworthy and that they are truly collaborative. I feel like a lot of times people in positions like myself and my colleagues, we are thinking of ways that we can enact change without actually knowing if that change is something that is needed or if it's the change that needs to be prioritized.

And the ways that we go about doing that, I think, can often be very opaque if we're not actually living that experience. And so I think it really takes, and this is something that you touched upon at the very beginning, talking about one of the upcoming sessions, is being able to really take into account mixed methods approaches. So not only having this quantitative data, perhaps about health outcomes, but what are some of the qualitative data that we need to understand and to know that can help us not only understand what questions should be asked, but what is the meaning of some of our quantitative data? Because the meaning might be different than what we assume it to be.

And so I think having community-led research, community-led development of research topics is something that's really critical. That's something that we are not doing to the extent that I would like us to do, but that we are focusing on. And we work very closely from the very start of our detailing campaigns, including conceptualizing what the campaign topic will be through all of the analyses with our community partners to make sure that we are truly collaborating and not doing a superficial collaboration.

Bevin: That's so important. And I want to reflect back because you just were spitballing some really juicy stuff. And so I want to grab some of the nuggets there. I really want to hit on that piece that you said around making sure you're going in the direction that is actually right for a community, that is actually right for a patient versus what it sounds like to me is just not making assumptions, not making assumptions just based on data, not making assumptions based on talking to one patient one time. And so what that sounds like to me is just keeping the conversation always open. And again, treating communities and patients as the experts, not just kind of saying, oh, we'll get your feedback once or twice, or we'll make sure we run this by you, but actually having them at the helm side by side is so key. So thank you for that. And what I want to do is grab a question from the audience and throw it to both of you. So I'm going to start with Sarah, and then I'll bounce it back to Carla.

We have a great question from Jess Alward, who does detailing work on infectious disease in New Hampshire, and is also one of our trainers. She says, do you feel that the backgrounds and lived experiences of the detailers plays an important role in helping providers embrace

the idea of a more inclusive practice? I love this question, Jess. Sarah, what's your immediate take on that?

Sarah: Absolutely. I think all of our experiences are what we walk by, right? That's where we come from, and they influence how we react to things, how we talk about things. And so, you know, if you have a lived experience and you can actually delve into that and share it with somebody, that really is a lot more powerful than just sprinkling the top of this is some information, this is what I've heard. So I really do believe that wherever you come from, that truly influences how you can deliver information and even some of your passion behind it as well.

I go to suicide prevention. We know that suicide prevention, especially in the VA, is really important. And when we first started talking about suicide prevention, I can't tell you how many of our detailers, leadership in pharmacy were like, what are we going to do about this? This has nothing to do with us. We don't need to touch this. And yeah, because of, you know, we're not therapists, you know, maybe we can limit medications, but there's not a lot of evidence behind that. Why would a pharmacist come talk to me about this? However, we have noticed now because we raised awareness and through lived experiences of having loved ones or friends who have gone through suicidal ideation or have died by suicide, that all of a sudden the message changes.

The passion is much bigger. And these individuals who are the loudest naysayers are now the ones that are putting together the most important products. And their area that they're practicing in is leading in outreach on suicide prevention. So yes, absolutely. I think that we all walk different paths and that path really influences how we see the world.

Bevin: Incredible. Yes. I've never thought about it quite that way. And that just serves to further bolster a lot of the, I don't want to call it marketing, but the sort of underlying themes we try to impart with detailers who are with us today, who join us during our community check-in calls, that who you are is not just okay to bring to your detailing visits, it's sort of critical, especially if there is a passion there. And, you know, when I hear you said sprinkling, it made me think of what Carla said about just, you know, Carla, you used some sort of example that involves something with your hands, but it also implied something around, you know, just a surface level, right? We don't want to be surface level. These are people's lives we're dealing with.

And what a great way to look at something where a pharmacist might say, well, what impact could I possibly have on suicide prevention? And then to show them, oh, it's an incredible impact. So thank you for sharing that on the fly, Sarah. I'm going to throw the same question to you, Carla. How is who we are as detailers important when meeting with clinicians and trying to move the needle on inclusivity? What are your thoughts about that?

Carla: Well, I think especially if you're able to produce a very diverse, in terms of many different aspects, detailing group, then that allows your targeted healthcare providers to gain a more comprehensive understanding of the topic simply from their lived experiences. And I also think that it provides an opportunity potentially to see people who are not often in positions of leadership. And I would say that being a detailer is one.

You're here to offer increased knowledge to a healthcare provider to see them in that position. And I think there's something that's very powerful about that. And I think going back to this idea of getting comprehensive information and being able to see various perspectives is getting us to this idea about how language creates realities.

And I think language not only creates, but it also reinforces our reality. So for example, at the health department, we have started using the terminology, people who are racialized as, as opposed to people who are Asian, people who are Latino, because people are not actually black or white to use a common example, but they are racialized as such. And race is a myth.

And the idea of race has real effects and that it provides a cover to racism and either privileges or provides barriers to people based upon how they are racialized. And I think when speaking with people, according to racialized classifications and presenting data that are stratified by race, we should really practice this highlighting of racialization. So for example, I encourage people, instead of referring to white patients, we can more accurately describe a group by saying patients racialized as white.

And being intentional about the language that we use as detailers should also extend beyond that of racial classification. So for example, when discussing gathering support for a project, it may be more impactful to refer to investors and investing instead of saying gaining buy-in. Instead of referring to culturally informed or trauma-informed care, we should refer to culturally responsive or trauma-responsive care. And these are words that really serve to create the reality that they refer to. And I think that, you know, we probably could all agree that we'd rather engage with a person who is not just trauma-informed, for example, but who also is able to be trauma-responsive, which conveys action as opposed to passivity.

Bevin: That's really, really helpful. And it also leads me to think about or to speak about something that we really want to bring up here at NaRCAD, which is, you know, language is ever-changing. That's not something new to any of us. And so one thing, I mean, this is new to me, Carla, you know, we always look to you just because you really are at the cutting edge of a lot of this work, as is your team.

When we think about our own language as detailers going in to have these sessions and to reframe language, those of you who may join this afternoon's workshop on connecting with clinicians who may use stigmatizing language and the reframe, how do you reframe? How do you know enough to understand why you're reframing? Really being curious, really being committed to understanding language and knowing that language will continuously morph, that there will be more and more information and data and resources and studies about what kinds of language are the most supportive and reflective and empowering, so that when folks say, well, why do I have to use this language, right? When folks say, I just can't keep up with all of this, being able to go at it with some data about how the language impacts and empowers and uplifts patients is also really important.

And so that's something that we at NaRCAD want to be able to continue to do, to have community meetings about, to kind of ponder some of these things, to look at sources, to look at who is doing this work and invite them to speak, invite them to challenge us and stretch our brains and hurt our brains about this kind of work, because if our brains aren't being stretched, then we're not doing it right, especially when it comes to language.

Speaking more about language, I wanted to ask you a question, Carla, that I know we spoke about a few weeks ago. There's language and then there's also, you know, language is sort of external, right? It's an expression of what we think, what we see. It's a reflection of what we perceive. When it comes to using language to take this external action to improve outcomes to improve healthcare, what needs to happen first?

Because you've talked to us before about internal reflection and that's something that many of us maybe in a conversation where we hear a clinician say something and our brain goes ding, that's not right, that's stigmatizing, that's not the right language. But how do we reflect our own

internal process? How do we catch ourselves and our own biases in action before we take that external action? Would love some of your thoughts on that.

Carla: Yeah, and you definitely touched upon something that is for me really personally frustrating. I think when we began looking at teams and agencies and organizations that are attempting to create externally facing projects and products without first doing that internal work and reflection, it means you're building something on a very shaky foundation. And in particular, with a lot of the focus that I have in my work on race and racism, I've encountered a very widespread lack of understanding about what race is, what racism is, and is not, what human genetic variation is. And this includes among healthcare professionals.

And to be clear here, race is a social classification that's based on assumptions about ancestry and appearance, and it's not a biological one. So racism essentially created race as a justification for colonization, exploitation, and enslavement. But race, to be noted, is not natural. It's not fixed. It is not based on biological differences. And so all of this makes it highly problematic and a really poor and inaccurate method for classification when we're doing our work.

And I think the consequences of making something that is false real are really seen in pervasive health inequities. And as you said, it's really imperative for teams and organizations to embody the principles that they advocate externally. And this holds true in the context for anti-racist work.

And so although race is a fiction, it has become verified and has real consequences. And despite being a social construct, has these real-world effects. So I think understanding that and being able to determine how it impacts access to privilege and the opportunity is the very beginning of being able to reflect upon how this thing is impacting not only the projects and the people and the places where we aim to make change, but it's impacting ourselves.

We can't divorce ourselves from that reality. And I think that if a team or an organization hasn't thoroughly examined and addressed its own internal biases, attempting to implement effective anti-racist practices or anti-stigma practices becomes an exercise in fertility. And there becomes this disconnect between the external goals and the internal practices.

And that creates a really hollow echo chamber. And without genuine self-reflection and commitment to dismantling internal biases, any external anti-racist efforts really fall flat and will lack authenticity and credibility. And I think moreover, this inconsistency can perpetuate harm by reinforcing some of these very systems of oppression or stigma that the organization or team actually aims to oppose.

And so I think that we also need to highlight how for individuals who are racialized as non-white or as anyone who is of a marginalized group, participating in such endeavors within a team that hasn't addressed its own biases can be profoundly stressful and detrimental to their well-being. And it really places an undue burden on them to navigate a space that may not be safe or supportive. And I have personal experience with this on teams that have been aimed at mitigating the impact of racism externally, but really fell short on examining how biases and harmful behavior interact within the team.

And this led to several team members who were racialized as non-white being disengaged and leaving the team entirely, which then of course has a negative impact on our ability to produce quality and authentic work. And so being able to prioritize internal transformation involves cultivating a culture of self-awareness. So making sure it's something that touches all aspects of our work, creating that culture, having reflection, open dialogue, continuous learning.

It requires that we all think critically about the ways that we may uphold stigma or white supremacy and really stand together against some of these harmful practices, whether it's in terms of a structural oppression or within like everyday stigma or biases. And I think the most impactful anti-stigma and anti-racist activities take place in the places where we live, where we work, where we play. And I think understanding that it starts very locally, that it starts with us, it starts at home, is key to be able to take that first step.

And it also must be said that trying to be clear about our own biases isn't easy. I am deeply engaged in this work as well as in school, and it's difficult for me as well. And I think that even for scientists and healthcare professionals who have been trained to follow the scientific method and engage in a skeptical analysis of the world around them, this can really be a challenge because regardless of profession, most of us are not trained to recognize our own biases, which is essentially like the air that we breathe.

And so the initial work is really a challenge, but it is work that can be done and really must be done if we are to live in a society that's free of biases and stigma. And I have to applaud the entire NaRCAD team for centering this work and being able to start this conversation and think about actionable ways for us individually and as a group to move forward and focusing on creating a more equitable field in terms of healthcare. And Ryan, the book Racism, Not Race is an excellent book. I was going to recommend it again today. I can drop the title. It's called Racism, Not Race.

Bevin: Yeah, thank you. Yeah, just for everyone who was just listening and not watching in the chat box, Ryan Anderson just said that he heard Carla speak in the past and recommended the book Racism, Not Race. So Carla, while you're looking for a link to that, I want to reflect on all of the good stuff you just said as much as I possibly can.

I think one thing that's so key to admit is when we're over our heads. And I would take a guess that many of us feel over our heads in areas like this. So some of this is very much rooted in academic theory, trying to find, get down to the base of what is race and these constructs.

And those are things that we at NaRCAD can't do over the next two days. So we want to just be clear about what our limitations are. But what we are committed to is saying when we don't know, when we don't know something and to say it's not enough anymore to say we don't know, so we're not going to look at it.

And I think that's where we were here at NaRCAD five years ago. Gee, this is coming up a lot. We don't know what we're doing. And instead of hiding behind the we don't know what we're doing, coming out and saying, can we all talk about what we think we know, what we want to know, what we are afraid to know, what we need to look at, what we don't know how to look at. And so what Carla was saying about the detrimental impacts of not being able to understand your own biases and then go in and put a lot of work into something with a lot of structure that is meant to help but ends up harming is a way of unintentionally continuing to have a negative impact and continuing to, without meaning to, create harm.

And so I recommend that where we can all start, especially if any of you are as overwhelmed as I know that I've been in areas of this, especially as a white person who wants to be an ally and doesn't know where to start, is to keep trying to break down information into digestible nuggets and look for an actionable piece.

I will say, and again, we know 95% that we said of the program that is folks who are diverse. Unfortunately, the session I want to plug again is our one non-diverse speaker, which is Mike Fisher, our white male. But I will say one thing he is looking at this afternoon that is the

beginning of a conversation is how do we start building our interventions thinking about the systemic issues with acquiring data that is not free of bias? What do we do to try to start working with that? And so again, for those of you who may have a very black and white or all or nothing approach to things and you want to figure out how to do it before you do it right so that you don't cause damage and so that you don't get it wrong, many of us are going to have to continue to embrace being part of a think tank, to be part of a group that continues to say, hey, I'm lost. Hey, I think I got somewhere. So please do stand by us with that and each other.

Carla, looking to you for guidance is something that we want to do while also not making it your job to inform the rest of us because you are a woman of color to tell us what we should be doing as a group who is predominantly white. So we need to be looking at all of this. We need to be talking about all of this. And we need to be thinking about how we can day by day involve ourselves in somehow acquiring more information and letting it kind of move around in our brains.

And with the acquiring information, it's always training. So I want to go back to our training expert here, Sarah from the VHA, who I know, Sarah, you do lots and lots of training. Would you say it's sort of the bulk of your job? How much would you say it makes up of the work you do?

Sarah: Training is the majority of what I do, either as didactic learning through national presentations that we get detailers to share their nuggets on or it's running smaller trainings to upskill them on communication skills or specific topics.

So yes, I would say the majority of what I do is training. It's probably about at 75%.

Bevin: Okay. So in that training, and I know you just said that you went to a training on inclusive language recently. How was that for you? Did you go to that training and feel like you had some nuggets to work with? Did it fall flat? Where do you see like space for certain kinds of training that's desperately needed?

Sarah: I found it very, very valuable because I think, especially now that I'm living in the South, like it's really ingrained into us to say, yes, ma'am, yes, sir, or Mr. So-and-so, Ms. So-and-so, when you're calling somebody. And really what we need to do is ask individuals how they'd like to be referred to.

So how do you like me to refer to you as? Some people may have a different name that they prefer you utilize versus perhaps they have a dead name. And if it's still in the chart as their dead name, you could immediately shut them down when you're engaging in patient care if you don't ask. But you also have to be very gentle with asking as well, because we have diverse generations and opinions in their beliefs about using different language inclusivity.

And so you also have to make sure that the way you ask is very general. How can I make you feel safe and respected? I mean, stuff that is very general, very open, not a check mark answer of, you know, what is your sexual orientation? You know, just general questions like that, because that can also for some people, it can make them feel included. And for others, it may turn them away from the situation based on their lived experience and what they've gone through. And they're also on the journey of learning as well.

Bevin: I really appreciate that. What you're talking about is again, stepping away from a demographic approach. Where do you fit in? What boxes can we squeeze you as a patient into or even you as a clinician into when we are looking at, you know, collecting data from whom we've spoken with? And I just wanted to clarify to the piece about dead naming, I'm

pretty sure maybe a lot of folks here know this, this was relatively new to me. The piece of not calling someone by their birth name, if they have changed their name to more appropriately reflect the gender expression that they've chosen. So again, Sarah really hits on something important.

In just one moment, any of us, but particularly clinicians may break down a trust between themselves and a patient by doing something that is not, I want to use the right language from Carla now, culturally, not just informed, but culturally responsive. And asking a question that sounds so simple, but is so powerful. I want to repeat the fact that Sarah just said, how can I make you feel safe and respected? That is an incredibly powerful question that you could ask anybody with whom you're speaking within your professional and personal life.

But in particular, we are looking more and more, especially with the programming we have over the next couple of days, but with our work in the future here at NaRCAD, how can we help you as detailers find ways to model inclusive and responsive language for clinicians so that they can approach their patients in a way that is trustworthy? That isn't just as Carla had said, you know, I'm trustworthy on the face, or I'm doing this thing that should build trust, right? But actually being accountable, being transparent. And Ryan says here in the chat box, when doing gender expansive academic detailing, we spend a lot of that time focusing on language. And Ryan will be presenting over the course of our next two days as well.

I realize that 60 minutes is nowhere near enough to even start getting our feet wet in some of this. But I absolutely just want to say thank you so much for getting us thinking, for making a space and joining us to talk about what it really means to lead in academic detailing. You both come from just such rich backgrounds of expertise and lived experience.

I could ask you a million more questions, but we only have 60 seconds left. So with that 60 seconds, I want to say thank you so much to Sarah and Carla to know that we will be continuing to invite you as leaders in our field to speak to our community, to share ways that you think and know we should be moving forward, to tell us when you're stumped, and you can help us help you. Much of this, again, is continuing to be committed to saying when we don't know, standing up for our collective humanity and remembering those patients that are at the tail end of every detailing session that we carry out. So thank you very much Sarah and Carla. We're so grateful to have you with us today.