

**Discriminative Nursing Care Practices Towards Patients with Opioid Use Disorder in the  
Hospital Setting: How Knowledge and Social Attitudes Impact Care Delivery**

**A Dissertation Presented for the  
Doctor of Philosophy  
Degree  
The University of Tennessee, Knoxville**

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May 2024**

## **DEDICATION**

This project is dedicated to all nurses working in today's challenging and ever-changing health care environment and to those who strive to provide holistic, compassionate, and equitable care to all patients. Thank you for your determination and for your ceaseless efforts to improve patient care and the nursing profession.

This project is also dedicated to my family, Mike, Mickey, and Juliette, who were constant sources of support and love over the past three years. Thank you for believing in me and encouraging me every step of the way. To my dad, thank you for being my biggest cheerleader, always. To my mom in heaven, thank you for your fierce love no matter what. I know how proud you are. To my colleagues at Mississippi College School of Nursing, thank you for allowing me the time and space to follow this dream, and thank you for supporting me during the most challenging times. To my colleagues and friends pursuing their doctoral degrees alongside me at UTK, your ambitions and your tenacity to achieve them amaze me. Thank you for inspiring me day in and day out during our graduate school journey. And finally, to my professors at UTK, thank you for your guidance and steadfast support. Your expertise helped me learn and grow as an academician, researcher, and a nurse; but it was your steadfast encouragement and compassion that has allowed me to reach this milestone.

## ACKNOWLEDGEMENTS

I would like to acknowledge and thank my dissertation committee members, Dr. Cristina Barroso (co-chair), Dr. Jennifer Shearer Miller (co-chair), Dr. Nan Gaylord, and Dr. Shandra Forrest-Bank. Thank you for your support, guidance, and expert evaluation of my dissertation work. Thank you, Dr. Barroso, for your unwavering encouragement and compassionate mentorship. Thank you, Cary Springer, for your statistical expertise and for the time and patience you extended me during the data analysis process. Thank you, Dr. Elyssa Wood, for working with me to understand your important research and the work of your many talented colleagues. Thank you for your advice and gracious support all along the way. Thank you, Dr. Sandra Thomas, for believing in me from the moment I applied to graduate school. Your honesty, leadership, and your undisputable love for doctoral nursing study inspired me many times over the past 3 years. And finally, thank you, Dr. Samereh Abdoli, for challenging me to methodically explore concepts in nursing, and for helping me identify the phrase *discriminative nursing care* which I have used throughout my doctoral work.

## ABSTRACT

Discriminative nursing care (DNC) practices towards patients with opioid use disorder (OUD) is a current phenomenon negatively affecting patient care and patient outcomes. It leads to delays in care, insufficient pain control, and feelings of guilt and shame, and it is linked to self-isolation, social isolation, social rejection, and even unemployment and housing disruption which perpetuate a dangerous cycle of inequity that is hard to overcome. In some cases, OUD stigmatization even increases morbidity and mortality rates. OUD stigmatization and discrimination are real problems in today's health care climate due to the vast number of people affected by OUD and the negative outcomes associated with the stigmatization process. An integrative review following Whittemore & Knafl's (2005) updated methodology was conducted to ascertain the state of the science of this phenomenon. Four themes emerged in this review, and the theme *nurses' lack of knowledge* was identified as the main facilitator of DNC towards those with OUD. Grounded in the Health Stigma and Discrimination Framework, which was operationalized as a middle range nursing theory, a secondary analysis of data from the Perception of Opioid Use Survey was conducted to determine the association between nursing knowledge, along with other variables, and nurses' perceptions of their abilities to provide equitable care to those with and without OUD. Important findings were discussed, and implications and recommendations for future nursing research, education, nursing practice, and policy were offered. Qualitative case study research related to nurses' age, years of experience in nursing, and their perceptions of their abilities to provide equitable care to patients with stigmatized health conditions is a key recommendation for subsequent research.

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# **CHAPTER 1**

## **INTRODUCTION**

Every day, people are admitted to hospital care for myriad reasons including illness, surgery, diagnostic intervention, and palliative care, just to name a few. In fact, over 34 million people in the United States were admitted to hospital care in 2021 alone (American Hospital Association [AHA], 2023). Goals of hospitalizations involve curative care, long-term treatment, and palliative care. No one enters the hospital expecting to be stigmatized or discriminated against by the very health care professionals providing their care, but unfortunately, it does happen. Health care providers, including nurses, have delivered discriminatory care towards patients because of patients' health conditions (El Rasheed et al., 2016). Hospitalization alone can be a stressful and frightening experience and can lead to negative physical and mental health outcomes (Chang, 2020). Moreover, stigmatizing or discriminating against patients because of a health condition can lead to additional negative health outcomes during and after hospitalization. Nurses who treat patients differently because of a health condition perpetuate discriminative nursing care (DNC), or the unequal treatment provided to a patient based on a health condition (i.e., illness, diagnosis, comorbidity, or past condition) or an associated attribute (i.e., lifestyle, age, personal choice, socio-demographic status) or a combination of these factors (Bernier & Barroso, 2024).

## **Background**

Nurses have acknowledged stigmatizing and stereotyping patients with opioid use disorder (OUD), (Horner et al., 2019; El Rasheed et al., 2016) which compromises the quality of health care administered to this patient population (Horner et al., 2019; Hawk et al., 2022). OUD involves the chronic misuse of opioids and is a medical diagnosis recognized by the American Psychiatric Association DSM-5 (Dydyk et al., 2022). OUD falls under the umbrella of the more general category of substance use disorder (SUD), and it affects over 16 million people globally

(Dydyk et al., 2022) from all socioeconomic, cultural, and educational backgrounds (Centers for Disease Control and Prevention [CDC], 2022). Despite its global reach, OUD is an extremely stigmatized disease (Hawk et al., 2022). Health care providers including nurses have been found to perpetuate stigma and discrimination towards this patient population which can result in negative health outcomes. Patients experiencing OUD perceive receiving disparate treatment compared to those without OUD and this disparate treatment includes being judged or blamed for their illness(s) (Blair et al., 2021; Simon et al., 2020), inadequate pain control (Horner et al., 2019), delays in care, and poor communication among health care providers and with the patient (Jaiteh et al., 2019). Stigmatizing behaviors reported by nurses include providing insufficient pain control, spending an inadequate amount of time with the patient (Horner et al., 2019), and generally providing unequal care to those with OUD compared to those without OUD (El Rasheed et al., 2016).

### **Scope of the Problem**

Stigmatizing patients with OUD is a real problem in today's health care environment because of the vast number of people affected with OUD, and because of the negative health and social outcomes that can result from DNC. Beyond negative health outcomes for individuals with OUD like delays in care (Jaiteh et al., 2019), inadequate pain control (Horner et al., 2019), leaving the hospital earlier than advised (against medical advice) (Simon et al., 2020), and negative influences (intentionally or unintentionally) of treatment choices (Shreffler et al., 2021), DNC towards those with OUD has been linked to reduced quality of life, self-isolation, social isolation, and social rejection for individuals and their families (Earnshaw, 2021). Additionally, OUD stigmatization and discrimination have downstream impacts on employment and housing. Unemployment and housing disruption can be directly or indirectly related to OUD

stigmatization, and they can perpetuate a dangerous cycle of instability, substance use issues, morbidity, and even mortality (Earnshaw, 2021; Richardson & Epp, 2016; Lopez & Reid, 2017; National Health Care for the Homeless Council [NHCHC], 2019).

### ***Addressing the Problem***

To address this important problem, an integrative literature review was conducted in to evaluate and analyze the current state of the science related to DNC practices towards patients with OUD in the hospital setting. Findings from this review spurred investigation into the theoretical underpinnings of health condition stigmatization, and an analysis and evaluation of the Health Stigma and Discrimination Framework (HSDF) was completed. Based on the current state of the science of DNC towards those with OUD, and using the HSDF as a theoretical framework, a secondary analysis of data from the Perception of Opioid Use Survey (POUS) administered in 2022 was conducted to examine the relationships between nursing knowledge, demographics, personal experiences, and social attitudes and nurses' perceptions of their abilities to provide equitable care to those with and without OUD.

### **State of the Science.**

This state of the science integrative review incorporated aspects of Whittemore & Knafl's (2005) updated methodology to conducting an integrative review and features of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 flow diagram for updated systematic reviews (Page et al., 2021). Recent, relevant literature was searched, studied, and evaluated following, and four themes of DNC emerged: patients' perceptions of DNC, nurses and other healthcare providers' perceptions of DNC, nurses' lack of understanding, and recommendations for improvement. The main factor contributing to DNC practices towards those with OUD was found to be nurses' lack of knowledge (Bernier & Barroso, 2024). Nursing

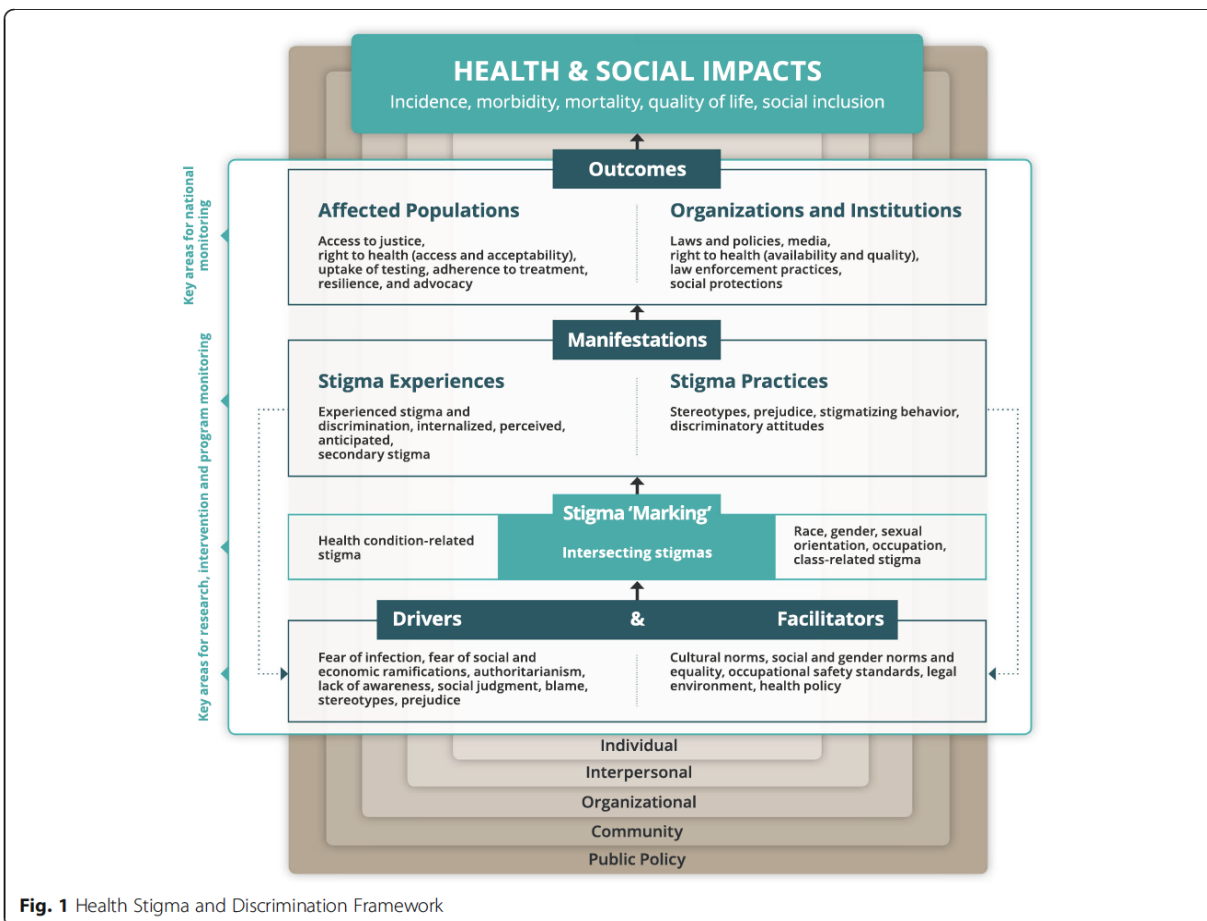
school curricula are structured and dictated by accrediting organizations, and benchmarking thresholds are mandated by standardized licensing bodies as well as hospital protocols. Nurses working in hospitals must meet these benchmarks and standards to care for patients, but a lack in nurses' knowledge endures. A critical gap needing attention includes measuring nurses' knowledge as well as their knowledge and understanding of how to fairly care for patients experiencing OUD. The state of the science manuscript titled "Discriminative Nursing Care Practices Towards Patients with Opioid Use Disorder in the Hospital Setting: An Integrative Review" is provided in Chapter 2 of this dissertation. The manuscript was published in the *Online Journal of Issues in Nursing*, a peer-reviewed scholarly publication of the American Nurses Association, in April 2024 (see Figure 3 in the Appendix at the end of this chapter for copyright permission). Dr. Cristina Barroso contributed to this manuscript and is a co-author.

### **Theoretical Framework.**

This dissertation is grounded in the Health Stigma and Discrimination Framework (HSDF) - a multidisciplinary theoretical framework developed by leaders in public health, psychology, social policy, epidemiology, social work, and medicine (Stangl et al., 2019). These leaders strived to develop a broad, comprehensive framework for application not just to one single stereotyped health condition like HIV/AIDS, obesity/overweight, or mental health issues, but rather to apply across all health conditions. The specific purpose of the HSDF is to guide research, social and healthcare policy, and intervention development and measurement. The overarching goals of its developers were to recognize and stop health-related stigma and to minimize the negative impacts of health-related stigma and discrimination on health outcomes (Stangl et al., 2019). The HSDF has been useful in guiding nursing and health care research and practices related to commonly stigmatized health conditions like HIV/AIDS or people living

with HIV/AIDS (PLWHA), COVID-19 infection, and human papilloma virus (HPV) infection and vaccination. Based on the inclusive format of the framework, the HSDF should be well-suited to ground research related to the stigma and discrimination surrounding OUD. A critical analysis and evaluation of the HSDF is provided in the manuscript titled “The Health Stigma and Discrimination Theoretical Framework: Analysis and Evaluation” in Chapter 3 of this dissertation. The manuscript was published in the *Journal of Nursing Doctoral Student Scholarship*, a peer-reviewed publication of the University of Pennsylvania, in December 2023 (see Appendix at the end of this chapter for copyright permissions).

The HSDF is organized into 3 “domains” or levels: drivers and facilitators, stigma ‘marking’ (the application of stigma because of a specific health condition(s)), and stigma manifestations. These three levels constitute key areas for research and intervention implementation where disrupting the health-related stigmatization process can occur. Furthermore, they influence individual and group outcomes which culminate in general health and societal impacts (see Figure 1). Causes of health-related stigma include drivers and facilitators (domain 1). Drivers trigger or enable health-related stigma and they are always negative. Facilitators, or factors that enable the stigma to begin or continue, can be positive or negative. Drivers and facilitators potentially result in stigma ‘marking’ (domain 2), which is the application of stigma to a person or group of people because of a health condition or other supposed difference such as gender, race, or sexual orientation. Stigma ‘marking’ can include intersecting stigmas, which is simply ‘marking’ with more than one health stigma or associated stigma (Stangl et al., 2019). Once stigma ‘marking’ occurs, stigma manifestations (domain 3) ensue in the form of stigma experiences (lived realities of those facing stigma) and stigma practices (beliefs and actions of those perpetuating stigma) (Stangl et al., 2019).



**Fig. 1** Health Stigma and Discrimination Framework

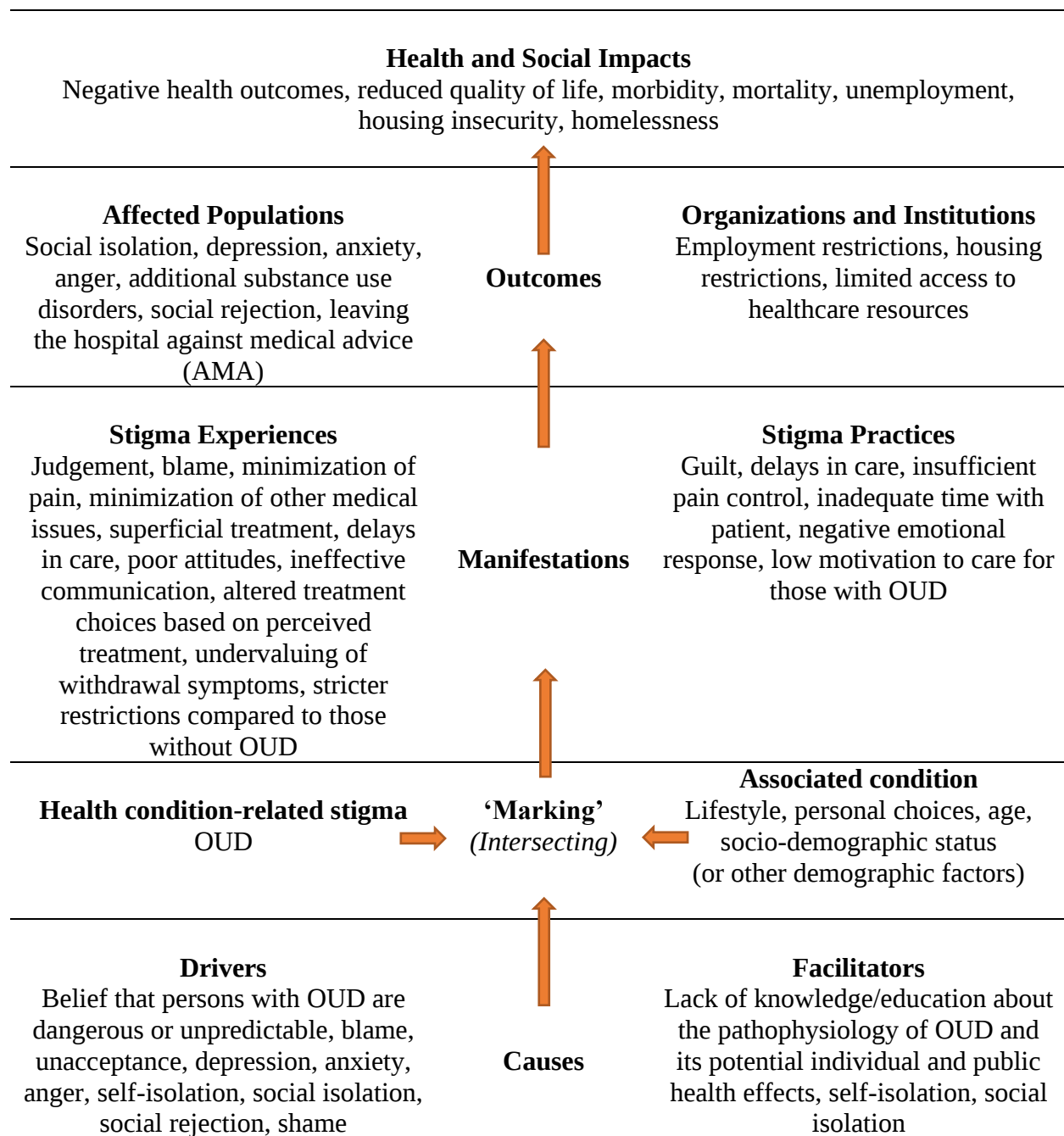
## Figure 1

*Health Stigma and Discrimination Framework* (published by *BMC Medicine* and used with permission from *BMC Medicine*)

Stigma experiences include experienced discrimination (stigmatizing behaviors carrying legal repercussions), experienced stigma (stigmatizing behaviors not carrying legal repercussions), internalized stigma (accepting stigmatizing traits), perceived stigma (assumptions of how a stigmatized person will be treated in a given situation), anticipated stigma (expectation of stigma based on a health condition or associated condition), and associative stigma (family or friends of a stigmatized person experiencing stigma themselves). These stigma experiences are the lived realities of the person or people experiencing health-related stigma. Stigma practices include stereotyping, prejudicial behaviors, discriminatory attitudes, and stigmatizing behaviors (Stangl et al., 2019). Drivers, facilitators, ‘marking’, and stigma manifestations have the power to impact health and social outcomes for individuals and groups including morbidity, mortality, quality of life, and social inclusion.

The stigmatization process outlined in the HSDF is applicable to the health condition OUD (see Figure 2). According to the HSDF, drivers and facilitators cause health-related stigma (Stangl et al., 2019). Drivers of stigma toward people experiencing OUD include the view that some may be dangerous or unpredictable, the view that those with OUD are to blame for their disorder, unacceptance (Yang et al., 2018), depression, anxiety, anger (Earnshaw, 2021), and social rejection (Earnshaw et al., 2013). Shame is also a major driver of stigma and is both considered the core of self-stigma (internalized stigma) and common in people with substance use disorders (Luoma et al., 2012; Reese et al., 2021).

Social and self-isolation are considered both drivers and facilitators of stigma (Earnshaw, 2021) because they can cause and enable stigma. The major facilitator of stigma associated with OUD is a lack of knowledge. Patients and nurses alike have acknowledged that nurses lack the



**Figure 2**

*Concepts and processes of discriminative nursing care practices toward those with opioid use disorder using the Health Stigma and Discrimination Framework by Stangl et al., 2019*

necessary knowledge and educational preparation to holistically care for those with OUD (El Rasheed et al., 2016; Hawk et al., 2022; & Simon et al., 2020).

Drivers and facilitators lead to stigma ‘marking’ as a direct cause of experiencing OUD and, at times, associated conditions like lifestyle, personal choices, and socio-demographic status. This ‘marking’ leads to stigma manifestations including the patients’ experiences (lived realities) and the nurses’ practices (stigmatizing and prejudicial behaviors and stereotyping) (Stangl et al., 2019). Stigma experiences perceived by those with OUD include the feeling of being judged and blamed for their disorder (Blair et al., 2021; Simon et al., 2020), minimization of pain and medical issues by health care professionals (Hawk et al., 2022), superficial treatment, delays in care, poor attitudes, ineffective communication (Jaiteh et al., 2019), altered treatment choices (Shreffler et al., 2021), undervaluing of withdrawal symptoms, and stricter hospital restrictions compared to those without OUD (Simon et al., 2020). Stigma practices towards those with OUD consist of labeling those with OUD as guilty of bringing the disorder upon themselves (i.e., shame) (Reese et al., 2021), delays in care, insufficient pain control, inadequate time spent with the patient (Horner et al., 2019), a negative emotional response to those with OUD (El Rasheed et al., 2016), and low motivation to provide care for this patient population (Mahmoud et al., 2021).

Stigma experiences and practices lead to outcomes for both the individuals experiencing stigma as a result of OUD and for organizations and institutions. While social isolation is a driver of OUD-related stigma, it is also an outcome of experiencing stigma. Stigma manifestations can contribute to social isolation which can be extremely detrimental to this patient population because of the need for support and social connections when working toward recovery (Earnshaw, 2021). Social isolation can lead to additional substance use issues, and the

social rejection that results from experiencing stigma can intensify social isolation. Likewise, experiencing stigma can lead to negative health outcomes like depression, anxiety, and anger, which can, in turn, lead to additional substance use (Earnshaw, 2021). An added individual outcome of stigma manifestations includes leaving the hospital too early (against medical advice), which increases the risk for negative health outcomes (Simon et al., 2020). Community outcomes of stigma manifestations include employment and housing restrictions related to required drug testing as well as limited access to resources aimed to improve the quality of life of those with substance use issues (Dineen, 2021; Earnshaw, 2021).

The overall health and social impacts of stigma and discrimination towards people experiencing OUD are staggering. Negative health outcomes can occur, persist, and worsen (Earnshaw, 2021; Horner et al., 2019; Jaiteh et al., 2019) leading to reduced quality of life and increased morbidity and mortality rates. Unemployment results from employers blocking opportunities for people in recovery or people with certain forms of substance use disorder (Richardson & Epp, 2016). This form of social rejection can further self-isolation, and a lack of employment can lead to housing insecurity and homelessness. Additionally, some public policies deny housing for people with current or previous substance use disorders, which, in turn, increases the risks of negative health outcomes and compromises the quality of life for those facing these challenges (Earnshaw, 2021).

The HSDF is an appropriate theoretical framework to guide this research project because of its functionality with all health conditions, especially in a highly stigmatized illness like OUD. The main strength of the HSDF in the context of this project is its practical application to OUD. Another strength includes the successful application of the HSDF in previous scientific work studying stigmatized illnesses like HIV/AIDS, COVID-19, and HPV. Furthermore, the

framework will be a good fit for future research and program implementation. Because the first three levels of the HSDF are ideal for disrupting the stigmatization process, implementing change to the facilitator, *lack of knowledge*, will be important. When the time comes to develop an OUD education program as a response to *lack of knowledge*, the HSDF, along with empirical evidence, will be vital mechanisms to inform the instruction of OUD as a disease and associated health-related stigmas (Stangl et al., 2019).

The main limitation of grounding this nursing research in the HSDF involves the reality that the HSDF is not a nursing theory or model. Rather, it is intended for use by researchers, policy makers, administrators, and program implementers across healthcare disciplines worldwide (Stangl et al., 2019). Grounding nursing research and practice in nursing theory has been shown to improve overall nursing care (Younas & Quennell, 2019), facilitate nursing knowledge growth, and enhance strategies to support nursing practice (Matney et al., 2015). However, it is not required for a nursing study to incorporate a nursing theory, only that the theory or model used includes four concepts central to nursing: human beings, health, nursing, and environment (Fawcett & DeSanto-Madeya, 2013). The HSDF explicitly involves human beings, health, and environment. The concept of nursing is open to interpretation by those developing and using the theory or model (Polit & Beck, 2017). Because nurses are a central concept in the operationalization of the HSDF to the health condition OUD, the potential limitation of it not specifically being a nursing theory is mitigated and essentially nonexistent.

### **Secondary Data Analysis.**

To explore the relationships between nursing knowledge, demographics, personal experiences, and social attitudes and nurses' perceptions of their abilities to provide equitable care to those with and without OUD, several methodologies were used to analyze data from the

2022 Perception of Opioid Use Survey (POUS). The POUS is a valid and reliable survey tool measuring nurses' attitudes, knowledge, and practices towards patients using opioids by requesting responses to statements within four domains or scales. The scales include causative factors, community impact, self-efficacy, and social attitudes (Burton et al., 2021). Chi-square tests were used to determine differences between nurses' perceptions of their abilities to provide equitable care to people with and without OUD and education level, nursing experience in years, age, gender, amount of time in direct patient care, and nurses' personal experiences. To determine differences between nurses' social attitudes of blame ("people with opioid use disorder only have themselves to blame"), danger ("all people who misuse substances are dangerous"), and choice (opioid use disorder is a choice and persons who use opioids can decide to stop") with nurses' perceived ability to provide equitable care, *t*-tests were conducted. Finally, binary logistic regression was used to determine whether nurses' knowledge, demographics, personal experiences, and/or social attitudes can predict nurses' perceptions of their abilities to provide equitable care to those with and without OUD. The complete methods and results of this dissertation research, including a thorough description of the measures of the POUS and variables included for analysis, is written in the manuscript titled "Stigmatizing Patients with Opioid Use Disorder: Factors Contributing to the Provision of Equitable Nursing Care" provided in Chapter 4 of this dissertation. This manuscript will be submitted for publication to the *Online Journal of Issues in Nursing*, a peer-reviewed scholarly publication of the American Nurses Association.

## **Purpose**

The purpose of this dissertation research was multifaceted. Each aim is connected to the overall theme of DNC towards patients with OUD in the hospital setting, and the findings of both the state of the science manuscript and theory analysis and evaluation inform the aims of the secondary data analysis. The main objective of the state of the science manuscript was to answer the question: *what discriminative nursing care practices towards patients with OUD exist in the hospital setting?* Additional objectives were to identify the causes of DNC towards patients with OUD as well as recommendations to mitigate the problem. The aim of the HSDF analysis and evaluation manuscript was to investigate the HSDF through the lens of a middle range nursing theory. Finally, the purpose of the secondary data analysis was to examine the relationships between nurses' knowledge, selected demographics, social attitudes, and personal experiences and their perceptions of their abilities to provide equitable care to patients with and without OUD.

## **Assumptions**

Because the integrative review was focused on ascertaining the current state of the science of DNC towards patients with OUD, the review was not driven by any empirically based assumptions or presumptions. The review was prompted by experiences I had and faced as a working nurse in the hospital and by discussions with professors and classmates at the beginning of my doctoral studies. Analyzing and evaluating the HSDF as a middle range nursing theory assumed that, if operationalized in the context of nursing, the HSDF could prove to be a valuable and usable middle range nursing theory on which to base nursing stigma research. Stigma had previously been assessed tangentially through specific measurement tools focused on specific

stigmatized illnesses, but mapping the general stigmatization process for all health conditions from causes to societal outcomes was new.

Based on knowledge gained through the integrative review and additional reviews of literature, and using the HSDF as a theoretical underpinning, several assumptions were made before the secondary data analysis began. A significant relationship was expected between nurses' education level and experience level with their perceptions of their abilities to provide equitable care. Nurses have cited an insufficient knowledge base to adequately care for people with addiction issues such as OUD which can perpetuate stigma toward this patient population (El Rasheed et al., 2016). Likewise, nurses are more motivated to effectively care for patients with substance use disorders when they have personal experience with the disease such as a family member or close friend with OUD and past work in substance use treatment (Mahmoud et al., 2021). Therefore, nurses with more education and personal experiences related to OUD should perceive to provide more equitable care to patients whether they have OUD or not.

As explained in the previous section, the POUS is scaled into the four domains of causative factors, community impact, self-efficacy, and social attitudes. The domain of social attitudes is used to describe nurses' subjective evaluations of their own personal biases and opinions towards opioid use and misuse. This domain includes survey items focused on blame, danger, and choice (Burton et al., 2021). Based on current literature, a negative relationship was expected between nurses' social attitudes and their perceived ability to provide equitable care. Known drivers of stigma towards people experiencing OUD include opinions that those with OUD are to blame for their disorder and may be dangerous or unpredictable (Yang et al., 2018). These opinions led to the assumption that the more a person was blamed for their opioid use and

thought to be dangerous, the more stigma would be applied to them which would decrease the nurses' perceptions of their abilities to provide equitable care to patients with and without OUD.

## **Limitations**

A major limitation of this research study lies in the dependent variable of the secondary analysis – *the nurses' ability to provide equitable care to patients with and without OUD* – because it is regarded as self-perception and it is entirely measured through self-evaluation (Burton et al., 2021). As measured in the POUS, nurses define their ability to provide equitable care subjectively and based on their own opinion. Likewise, a limitation of potential response bias exists because of the sensitive nature of the topic related to nurses' perceptions of the care they provide (Burton et al., 2021). Participants of the 2022 POUS may have selected a response they assumed to be correct or socially acceptable rather than the response best reflecting their perceived ability to provide equitable care.

Limitations related to the integrative review exist and include the age of the review (it was completed in late spring 2022) and the restricted date range of articles published between 2016 and 2022. Important themes may have been missed because of these factors and a more current integrative review including articles published before 2016 and after 2022 is recommended. A limitation associated with the theoretical analysis and evaluation manuscript involves the processes chosen for analysis and evaluation. The processes used were Walker and Avant's (2018) six steps in theory analysis and Peterson and Bredow's (2019) middle range theory evaluation process. While both processes are relevant and applicable to current nursing science, utilizing other processes would likely provide a different analysis and evaluation of the HSDF.

A limitation consistent with secondary data analysis research such as this is the unstructured nature of post-hoc data analysis. Analyzing data from a previously conducted study has the potential to lead to coincidental findings rather than actual statistical relationships (Ross & Zaidi, 2019). Because the data for this study are already collected, these limitations will be addressed and minimized during manuscript writing. The potential for response bias will be acknowledged and the post-hoc structure of analysis will be explained so readers can consider this during their interpretation of the information (Ross & Zaidi, 2019). Limitations are expected in any research project, especially projects like the ones completed in this dissertation research because they address an area of nursing science with limited available research. While limitations are present in each of the projects completed in this dissertation research, the methods used for investigation, as well as the findings from each manuscript, are important to the growing body of nursing knowledge related to DNC towards patients with OUD.

### **Significance and Implications**

This research study is significant because of the real problem occurring in our hospitals. Patients with OUD are treated differently than patients without OUD by nurses during hospital care (El Rasheed et al., 2016; Simon et al., 2020), and this discriminative nursing care (DNC) contributes to negative health outcomes in individuals and communities (Bernier & Barroso, 2024; Horner et al., 2019; Jaiteh et al., 2019; El Rasheed et al., 2016). A documented cause of DNC towards those with OUD is a lack of opioid knowledge and the understanding of how to holistically care for someone with OUD (Simon et al., 2020). This research seeks to identify the relationships between nurses' education level, experience level, personal experiences, and social attitudes with nurses' perceived abilities to provide equitable care to patients with and without OUD. Establishing these relationships will, first and foremost, illuminate nurses' perceptions of

their ability to provide equitable care. Furthermore, this research will provide unique insight into the relationships of the selected independent variables with nurses' perceived ability to provide equitable care to nurses with and without OUD to help identify areas where intervention, and ultimately change, can occur. Using the Health Stigma and Discrimination Framework (HSDF) to guide the organization of the study findings will establish any facilitators and drivers found to be appropriate for targeted intervention. Subsequently, potential interventions aimed to intercede at the appropriate HSDF levels will be developed based on empirical evidence.

The implications of achieving disruption in the stigmatization process of those experiencing OUD are vast and applicable to individuals, communities, and health care organizations. Stopping opioid-based DNC has the potential to influence health care providers, including nurses, to halt stigma practices, and thus the stigma manifestations experienced by patients using opioids. This population would no longer face judgement for their illness or be blamed for it by health care providers. They would likely receive adequate pain control and timely care during hospitalization which could positively impact treatment choices after hospitalization. Patients experiencing OUD would be less apt to leave the hospital against medical advice (AMA) and, if experiencing withdrawal symptoms, these symptoms would be given the same attention as all other physiologic symptoms. Hospitalized patients would not solely benefit from a decrease in opioid-based DNC – nurses providing care to those using and misusing opioids would no longer experience the manifestations caused by perpetuating opioid-based DNC. They would no longer feel guilty for stigmatizing this patient population and they would not suffer the negative emotional responses possible with providing discriminatory care.

Eliminating stigma manifestations could, in turn, reduce the health and social outcomes of the OUD stigmatization process. Instances of social isolation and rejection, depression,

anxiety, anger, and additional substance abuse augmented by stigma experiences may decrease. Societally, unemployment, housing insecurity, and homelessness caused by the OUD stigmatization process may decrease, and overall health outcomes and quality of life could improve. The implications of stopping the OUD stigmatization process can begin with nurses and continue to all health care providers. OUD is a diagnosed mental health illness and the number of people affected by OUD continues to grow. OUD in and of itself carries myriad physical and mental manifestations and outcomes. Disrupting the stigmatization process associated with OUD is one way to improve the lives of those experiencing OUD, their loved ones, their communities, and society as a whole.

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## Appendix



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**CHAPTER II**  
**DISCRIMINATIVE NURSING CARE PRACTICES TOWARDS PATIENTS WITH**  
**OPIOID USE DISORDER IN THE HOSPITAL SETTING: AN INTEGRATIVE REVIEW**

This manuscript has been peer-reviewed and was published by the *Online Journal of Issues in Nursing*, a scholarly publication of the American Nurses Association, in April 2024. It is formatted according to 7<sup>th</sup> edition American Psychological Association (APA) guidelines. Dr. Cristina Barroso contributed to this manuscript and is a co-author.

## **Abstract**

Discriminative nursing care (DNC) is the act of a nurse treating a patient differently from another patient based on the patient's illness, diagnosis, lifestyle, personal choices, age, or socio-demographic status (or a combination of these factors) that causes the patient to perceive a difference in treatment. Health-related stigma and stereotyping contribute to DNC, especially towards patients with opioid use disorder (OUD) during hospitalization. This integrative review focused on evaluating and analyzing recent relevant literature related to DNC practices towards patients with OUD in the hospital setting to identify DNC practices and the causes of DNC, and to provide known and new recommendations to combat DNC practices towards this patient population. Literature from 2016-2022 was searched, evaluated, and analyzed, and four overarching themes of DNC emerged: patients' perceptions of DNC, nurses and other health care providers' perceptions of DNC, nurses' lack of understanding, and recommendations for improvement. Specific findings related to each theme are discussed. Gaps in the current literature, additional recommendations, and important areas for future research are identified.

## **Keywords/Phrases**

Discriminative nursing care, discrimination, stigma, health-related stigma, stereotype, opioid, opioid use disorder, OUD, substance use disorder, SUD, abuse, addiction, dependence, recovery

## **Discriminative Nursing Care Practices Towards Patients with Opioid Use Disorder in the Hospital Setting: An Integrative Review**

A basic principle of health care is all patients deserve equal treatment regardless of health conditions or individual characteristics. Discriminative nursing care (DNC) is the antithesis of that. At its core, DNC is derived from the phenomenon of discrimination- treating someone or a group of people differently from others (Merriam-Webster, 2021). In nursing, it is the act of a nurse treating a patient differently from another patient based on the patient's illness, diagnosis, lifestyle, personal choices, age, or socio-demographic status (or a combination of these factors) that causes the patient to perceive a difference in treatment. DNC is double-sided; it includes discriminatory practices by the nurse toward the patient as well as the perception of discriminatory practices received by the patient. The implications of DNC in the current health care apparatus are hypothetically sprawling, particularly due to the vast number of people potentially affected. Total hospital admissions in the United States, excluding ICU admissions, numbered 36,241,815 in 2019 (American Hospital Association [AHA], 2021). This figure indicates that just over 10% of the population of the United States were admitted to hospital care in 2019 and likely received nursing care. Thus, conceivably, 10% of the population could experience DNC during hospitalization.

Health-related stigma is a contributing factor to DNC. In his groundbreaking 1963 book, Erving Goffman abstracted the concept of stigma and the ideas he presented still ring true today. Goffman (1963) explained that stigma is a personal or group attribute labeled as less worthy, less valuable, or different. The attribute is discredited when it is stigmatized, and the effects of stigma can be far-reaching and long-lasting. Health-related stigma results from labeling human differences and the degree to which a health condition is stigmatized depends on its social

significance (Link & Phelan, 2006). A major element of health-related stigma is stereotyping which occurs when a person or group of people are marked with an unfavorable characteristic related to a health condition (Link & Phelan, 2006). The terms stigma and stereotype are often used interchangeably; and while they can both apply to a health attribute concurrently, stigma is more precisely defined as the simultaneous occurrence of aspects such as stereotyping, discrimination, and labeling (Link & Phelan, 2001).

Opioid use disorder (OUD) is a chronic condition involving the misuse of opioids which falls under the umbrella of substance use disorder. Diagnosis of OUD is recognized by the American Psychiatric Association DSM-5 (Dydyk et al., 2022). It affects an incredible number of the global population from all socioeconomic and cultural backgrounds (Centers for Disease Control and Prevention, 2022). To date, over 16 million people experience OUD internationally including more than 2.1 million people in the United States. Additionally, over 120,000 people die from OUD each year (Dydyk et al., 2022). Although OUD is far-reaching and affects people from all backgrounds, it remains highly stigmatized (Hawk et al., 2022). With OUD affecting so much of the population, many patients hospitalized for a separate illness or condition may have a comorbidity of OUD and, thus, could potentially experience DNC related to OUD. The purpose of this review is to answer the question: *What discriminative nursing care practices towards patients with OUD exist in the hospital setting?* Additionally, this review seeks to illuminate specific causes of DNC toward patients with OUD as well as recommendations to moderate the problem. An integrative review and analysis of current related literature was conducted to address these aims.

## Methods

### *Integrative Review Framework*

An integrative review is a summarization of current literature published on a specific topic. Through various methodologies used to appraise available scientific data sources, the integrative review presents a thorough understanding of a concept, theme, or problem. The goal of an integrative review of a nursing topic is to enhance the general understanding of the topic in order to improve evidence-based practices. Through delivering a comprehensive state of the science, an integrative review is a building block to future research, clinical practice, and policy applications (Whittemore & Knafl, 2005). This review incorporates aspects of Whittemore & Knafl's (2005) updated methodology to conducting an integrative review and features of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 flow diagram for updated systematic reviews (Page et al., 2021).

**Problem Identification.** Tens of millions of people are hospitalized in the United States each year (AHA, 2021), and many of these hospitalized patients have a comorbidity of OUD. Because OUD is a highly stigmatized illness (Hawk et al., 2022), those experiencing OUD that are hospitalized for a separate illness may face discrimination by the nurses providing care. The aim of this integrative review is to identify what DNC practices exist toward patients with OUD in the hospital setting. Furthermore, this review seeks to elucidate specific causes of DNC concerning this patient population as well as recommendations to mollify the problem.

**Literature Search.** Literature was searched using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database, PubMed, and Web of Science (WOS). Search terms were formulated with the assistance of University of Tennessee, Knoxville, Heath Science Librarians and included a range of related words and medical subject headings (MeSH terms).

Examples of search terms used include opioid, heroin, fentanyl, oxycodone, disorder, misuse, abuse, OUD, discriminate, prejudice, bias, stigma, practice, behavior, nurse, hospital, and inpatient. The following MeSH terms were included in the PubMed database search: Social Discrimination; Stereotyping; Health Knowledge, Attitudes, Practice; Social Perception; Nurses; and Hospitals.

The initial database searches yielded the following number of articles: CINAHL=24, PubMed=57, and WOS=27 (108 total). After applying the inclusion requirements of 1) peer-reviewed 2) current (published between 2016-2022) 3) original (excluding reviews) research 4) written in English and 5) associated with DNC and/or OUD in a hospital or related setting, articles from each database were: CINAHL=14 articles, PubMed=49 articles, and WOS=21 articles (84 total). Literature search revealed redundancies across the multiple databases; meaning, multiple articles were found on more than one database. Specifically, one duplicate article was found on both CINAHL and PubMed, one resulted from both CINAHL and WOS, seven were found on both PubMed and WOS, and eight resulted on all three databases. These 17 duplicates were removed which left 67 articles for data evaluation.

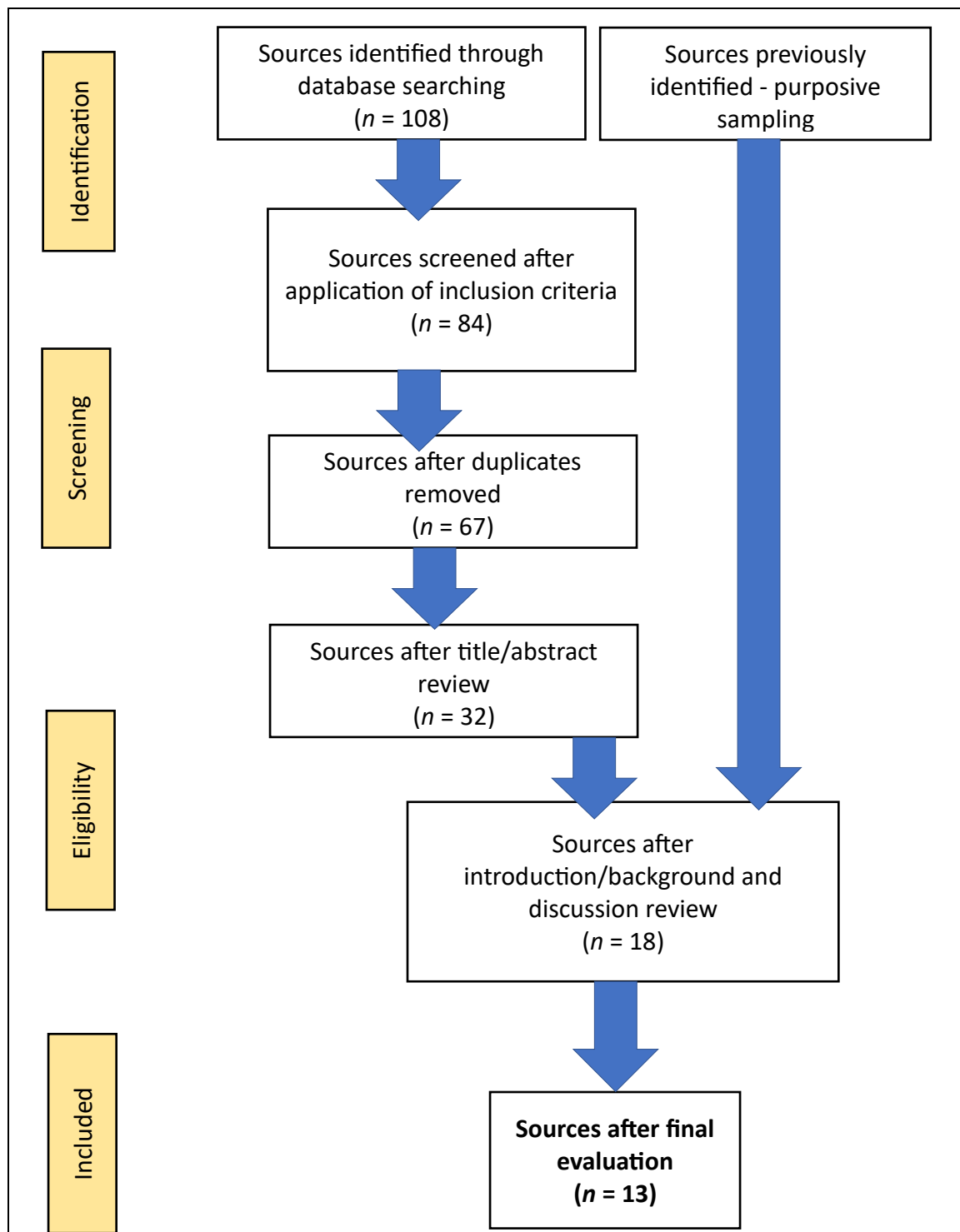
**Data Evaluation.** Whittemore & Knafl (2005) acknowledge that evaluating the quality of data for an integrative review is difficult and multifaceted. To achieve meaningful evaluation of articles produced in the initial database search, the author first reviewed the title and abstract (when available) of each article to identify key elements and excluded articles not germane to the aim of this review. This strategy eliminated 35 articles, leaving 32 articles for review. Purposive literature sampling from 2021-2022 provided nine additional articles to review, resulting in a total article count of 41.

The next step included secondary review of article titles and abstracts along with evaluation of the introduction/background section(s) and discussion sections. This allowed for evaluation of the content of each article and facilitated the decision to include or exclude articles. Articles that were included pertained in some way to discriminatory health care treatment, nursing care, health-related stigma, and OUD or an associated substance use disorder (SUD). Of the 41 articles, nine remained from the initial database search and four from the purposive sampled articles which brought the total count to 13 (see Figure 4). Detailed information demonstrating how each article met the inclusion criteria, including key findings and theme(s) emerging from each article, was documented and is available through a supplemental link.

**Data Analysis.** Data were extracted from peer-reviewed primary sources and analysis was guided by Whittemore & Knafl's (2005) updated methodology for conducting an integrative review. The classification system used for data reduction comprised isolating key findings from each source and grouping the findings according to emerging themes identified during evaluation.

## **Results**

Thirteen research articles were evaluated and analyzed to explore the research question *what discriminative nursing care practices towards patients with OUD exist in the hospital setting?* Two primary themes emerged: theme 1-patients' perceptions of DNC, and theme 2-nurses and other health care providers' perceptions of DNC. Data from each source fit into either theme 1, theme 2, or both theme 1 and 2. Subsequently, two secondary themes were developed because of supplementary data presented in most articles: theme 3-nurses' lack of understanding, and theme 4-recommendations for improvement. The DNC themes found in the included articles are shown in Table 1. Display of thematic extracted data is presented in Figures 5 and 6.



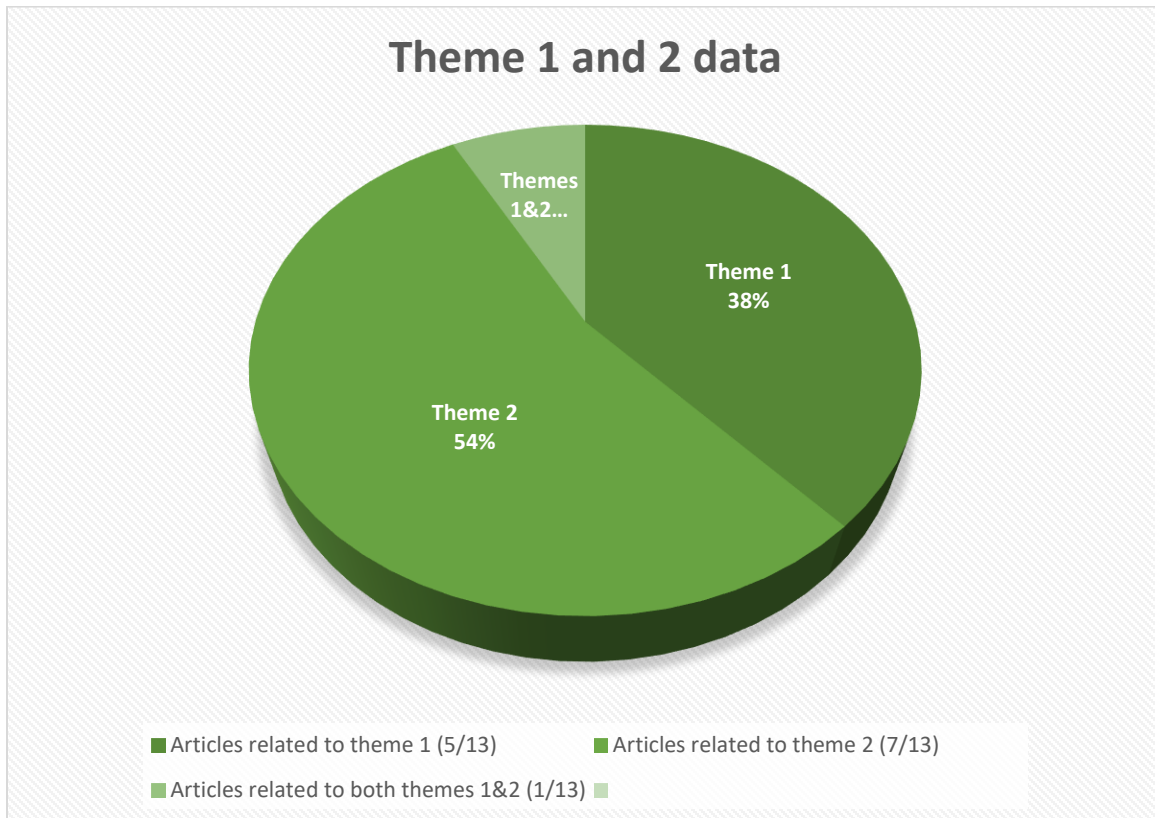
**Figure 4**

*Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) flow diagram*

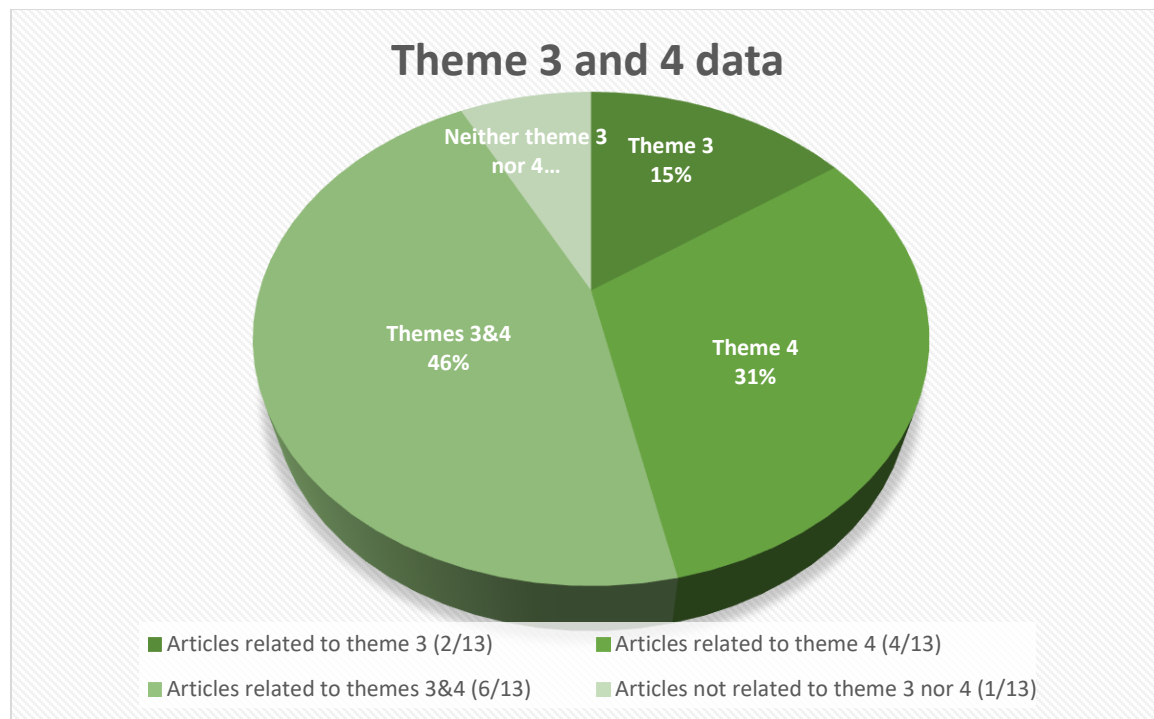
**Table 1**

*Description of Discriminative Nursing Care (DNC) themes in included articles*

| Theme                                                         | Articles<br>n (%) | Topic Relation to DNC                           |
|---------------------------------------------------------------|-------------------|-------------------------------------------------|
| 1: patients' perceptions of DNC                               | 5 (38%)           | Concepts that comprise DNC                      |
| 2: nurses and other health care providers' perceptions of DNC | 7 (54%)           | Concepts that comprise DNC                      |
| Both 1 & 2                                                    | 1 (8%)            | Concepts that comprise DNC                      |
| 3: nurses' lack of understanding                              | 2 (15%)           | Causes or perpetuates DNC                       |
| 4: recommendations for improvement                            | 4 (31%)           | Resolutions to DNC                              |
| Both 3 & 4                                                    | 6 (46%)           | Causes or perpetuates DNC or resolutions to DNC |
| Neither 3 nor 4                                               | (8%)              | --                                              |

**Figure 5**

*Data analysis – primary thematic data display*



**Figure 6**

*Data analysis – secondary thematic data display*

As discussed previously, DNC is double-sided. It includes discriminatory practices by the nurse toward the patient as well as the perception of discriminatory practices received by the patient. The first two themes identified during the review of literature pertain to the concepts that comprise DNC. The third theme (nurses' lack of understanding) include patient- and nurse-reported issues that can cause or perpetuate discriminatory care. The fourth theme involves recommendations for combating DNC from the patients and nurses' perspectives.

### ***Patients' Perceptions of DNC***

A major theme extracted from the integrative review process was patients' perceptions of being treated differently from other patients because they experienced OUD or a related illness presently or in the past. Some DNC practices reported by patients include feelings of judgement and blame (Blair et al., 2021; Simon et al., 2020), minimization of pain and medical issues (Hawk et al., 2022), superficial treatment, ineffective communication, delays in care, and poor attitudes (Jaiteh et al., 2019). Patients described receiving generally disparate treatment compared with patients who did not experience OUD or a related illness (Blair et al., 2021; Simon et al., 2020). Furthermore, patients expressed how health care professionals' biases and attitudes can be extremely influential, either intentionally or unintentionally, and can sway the treatment choices of people with OUD (Shreffler et al., 2021).

A patient's perception of DNC not only affects their hospital stay, but it also influences health care services after hospitalization. Furthermore, DNC can negatively affect the treatment success of those working through substance withdrawal. Dineen (2021) explored the discriminative actions people with OUD experienced during continued care after hospitalization and found that some nursing, post-acute medical, and rehabilitation facilities do not admit patients with a known OUD or other substance use disorder. Simon et al. (2020) explored the

reasons people with substance use disorders, including OUD, who are experiencing withdrawal symptoms choose to leave the hospital against medical advice and found DNC was a factor in the decision. Patients explained their withdrawal symptoms and related issues were ignored and inadequately treated. They also reported stricter restrictions being placed upon them, such as not being able to leave the floor on which their room was located, not being able to go outside, and limiting visitors allowed to see the patient.

### ***Nurses and Other Health Care Providers' Perceptions of DNC***

The second theme derived from the integrative review included nurses' perceptions of DNC along with other health care providers' perceptions of DNC. These groups are combined into one theme because of their common role of caring for patients with OUD. Nurses reported placing guilt and shame on people with OUD (Reese et al., 2021) and, at times, their families (Sapp & Hooten, 2019). Medical students observed nurses and physicians stigmatizing patients with a substance use disorder during treatment (Shreffler et al., 2021). Stigmatizing patients with a substance use disorder was confirmed by several research studies (Horner et al., 2019; El Rasheed et al., 2016; Shreffler et al., 2021) and was found to compromise the quality of health care provided to these patients. Stigmatizing behaviors resulting in compromised care included, but are not limited to, insufficient pain control, inadequate time spent with the care provider, a delay in care provided (Horner et al., 2019), and generally inequitable care compared with those without a substance use disorder (El Rasheed et al., 2016).

Along with stigmatization, stereotyping people with OUD was linked to nursing care (Cooney & Broglio, 2017) and the reasons cited for these actions are numerous. Nurses claimed to have insufficient knowledge to identify and manage the care of patients with addiction issues, which may lead to a negative emotional response that, in turn, perpetuates stigma toward this

patient population (El Rasheed et al., 2016). Nurses identified personal safety threats from patients with OUD and experienced an internal conflict when treating the pain of patients with OUD, questioning their own role in the patient's potential addiction-recovery cycle. Nurses also described feelings of burnout after long periods of providing care to patients with OUD, who they consider a more-demanding population (Horner et al., 2019).

Another nurse perception of DNC is the relationship between motivation level and discriminatory behaviors. Mahmoud et al. (2021) explained the motivation level of nurses to care for patients with substance use issues, including opioid use issues, can either positively or negatively impact care received by these patients. More specifically, low motivation in nurses was linked to negative patient outcomes such as delays in problem identification, limited health care access and resources, and an increased likelihood of dropping out of withdrawal treatment. Nurses' motivation was found to be significantly related to personal experiences. If the nurse had a family member with a current or previous substance use issue, that nurse was more motivated to provide quality care to patients with substance use issues. Additional aspects of nursing related to higher motivation in caring for patients with substance use issues include past work experience in substance use treatment, receiving continuing education related to substance use, nurse role adequacy, role support, work satisfaction, and self-efficacy (Mahmoud et al., 2021).

### ***Nurses' Lack of Understanding***

A third theme, nurses' lack of understanding, was revealed during literature appraisal. A major cause of DNC is insufficient nursing knowledge to adequately care for patients with substance use issues. Many nurses, even psychiatric nurses, do not feel they have sufficient knowledge to identify and manage patient care associated with addiction issues (El Rasheed et al., 2016). Uninformed and deficient preparation has been linked to emotional responses

triggered in nurses caring for patients with substance issues which can lead to a higher level of stigma toward this patient population (El Rasheed et al., 2016). Furthermore, patients with OUD feel that staff working in emergency departments lack the knowledge required to adequately understand and treat OUD and are, consequently, ill-equipped to do so (Hawk et al., 2022). In one study by Simon et al. (2020), patients with substance use disorder experienced feelings of mistrust from health care staff and speculated the poor treatment they received could be the result of the staff not understanding substance use disorders.

Along with the educational and knowledge level of nurses, the perspectives of nurses caring for patients with substance use issues was linked to DNC. Shreffler et al. (2021) found that nurses value the difficulty of recovering from substance use disorders less than physicians and medical students treating this population. This could result from inadequate instruction in nursing school and inadequate continuing education. Accordingly, the perspectives of nurses caring for patients with OUD may be a result of the very insufficient nursing knowledge discussed above.

### ***Recommendations for Improvement***

A majority of the articles reviewed included one or more recommendations for improvement. A common recommendation for improvement from patients and nurses was to generally increase the education preparation and knowledge base of nurses and others who care for patients with OUD (Horner et al., 2019; Reese et al., 2021). Another recommendation for improvement was increased effective communication. More specifically, effective interdisciplinary communication as well as open group communication between the patient and all members of the health care team were recommended because both were found to be major factors in successful treatment of people with OUD (Horner et al., 2019). Additional

recommendations for improvement include refining patients' transitions from the hospital to the community, standardizing care for those with OUD, and enhancing the emotional support available to patients with OUD (Horner et al., 2019). Turner et al. (2018) emphasized the importance of effective care planning from compassionate and empathetic screening to discharge planning geared toward open communication with the outpatient provider and supplementary resource provisions.

## **Discussion**

This integrative review focused on evaluating and analyzing recent relevant literature related to DNC practices towards patients with OUD in the hospital setting to identify DNC practices and the causes of DNC, and to provide known and new recommendations to combat DNC practices towards this patient population. Two main causes were revealed: nurses' lack of knowledge and understanding of OUD and the perspectives from which nurses provide care to this patient population. Several recommendations to combat DNC practices towards people with OUD were expressed in the reviewed literature. The major recommendation was to generally increase nurses' knowledge of OUD as a disease through directed education, comprehensive training, and experiential learning (Horner et al., 2019; Reese et al., 2021). Nurses need more education about OUD as a disease, the lasting consequences of OUD to those that experience it as well as to the community, and how best to care for patients with OUD. Through comprehensive training and education experiences, nurses will gain a more complete understanding of OUD (Horner et al., 2019; Reese et al., 2021). Ideally, dedicated education will lessen the instances of DNC toward patients with OUD.

Relatedly, increasing nurses' knowledge about OUD has the potential to change the perspectives from which nurses care for patients with OUD. The literature revealed nurses with

experience caring for people with substance use issues, such as caring for a family member with OUD, were typically more motivated to provide quality care to this patient population (Mahmoud et al., 2021). The perspectives from which these nurses cared for patients with substance use issues were more positive than those of nurses without such experience. Because nurses typically spend the most time with patients during a hospitalization, nurses' knowledge, and the attitudes and perspectives derived from this knowledge, are vital components of holistic nursing care (Shreffler et al., 2021). Providing holistic, non-judgmental, non-discriminatory care throughout the patient's hospitalization and into the discharge process is essential to a successful treatment plan.

The results of this review are important to the discipline of nursing and to patient care outcomes. Nurses carry their knowledge and life experiences with them when caring for patients which can lead to unintentional or intentional stigmatization towards patients with OUD. The four themes revealed during literature appraisal directly affect patient care and, therefore, patient outcomes. When patients receive disparate treatment, they are made to feel "less than" and, perhaps, less worthy of quality care. OUD is a highly stigmatized illness (Hawk et al., 2022) and patients with OUD could potentially experience DNC during hospitalization. DNC influences not only the experiences of hospitalization (Blair et al., 2021; Simon et al., 2020; Hawk et al., 2022; Jaiteh et al., 2019), but also the outcomes of hospitalization and post-discharge care (Dineen, 2021; Simon et al., 2020).

The purpose of an integrative review is to deliver a comprehensive state of current scientific literature to spark future research and to recommend ways to improve clinical practice and policy applications (Whittemore & Knafl, 2005). After conducting the current review, the key recommendation to decrease DNC towards people with OUD is to improve the educational

preparation of nurses in nursing school and within the hospital setting through continuing education and focused patient discussion. This recommendation aligns with a recent *Nursing Economics* call-to-action (Neville & Foley, 2020) for all nurses to combat the opioid epidemic from the perspectives of education, leadership, policy, economics, and research and focuses on the education of nurses in school and in the clinical setting. Nursing schools and the faculty charged with building curricula should expand instruction on OUD as a disease and highlight the potential implications of OUD to the patient, the community, and to the nurses providing their care. Additionally, nurses' attitudes and actions toward this patient population should be studied, and actions to combat stigma associated with OUD should be presented. Hospital systems should incorporate continuing education courses dedicated to OUD. This education should focus on how to recognize OUD, how to effectively manage the care of patients experiencing OUD, and offer ways to decrease stigma affecting this patient population.

Future research related to DNC practices towards patients with OUD is needed to further understand the etiologies of DNC and the ramifications it has on nurses and on patients. What additional factors cause nurses to treat patients with OUD differently than patients without OUD? Further study needs to focus on the immediate repercussions of DNC during hospitalization. From the patient's perspective: How does experiencing DNC affect the current health status of patients with OUD at the time of the discriminatory treatment and immediately following the treatment? From the nurse's perspective: How does delivering DNC to patients with OUD affect the nurse's perception of the quality of care they deliver? How does delivering DNC to patients with OUD impact the care delivered to patients without OUD? Longitudinal research needs to be conducted to examine the long term effects of DNC towards patients with OUD to the patients' overall health status as well as to the patients' relationship with opioids.

Finally, longitudinal study needs to be conducted to investigate nurses' coping mechanisms and evolving treatment of patients with substance use issues over the length of a career.

### **Limitations**

The limitations of the current review include the restricted date range of articles published between 2016 and 2022 and the inclusion criteria of peer-reviewed articles written in English. Important data and themes in literature published before 2016 may have been missed, and a future review could include a broader date range to include studies conducted before and at the beginning of the opioid crisis. Additionally, because OUD is a highly stigmatized illness, the responses of individuals in the studies reviewed may be incomplete or reserved based on the fear of judgement or ramifications from their statements/responses. A final important limitation is only literature pertaining primarily to OUD was reviewed which excluded the wide range of literature concerning SUD and related areas.

### **Conclusion**

The current integrative review provides an up-to-date, insightful summarization of DNC practices towards patients with OUD in the hospital setting. Relevant literature was evaluated and analyzed, and data and themes were extracted and organized to provide a comprehensive view of the relationships between those experiencing OUD, the nurses that care for them, and others involved. Key causes of DNC and stated recommendations for improvement were identified. New recommendations to combat DNC towards those experiencing OUD were presented and suggestions for future research were offered.

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**Chapter III**  
**THE HEALTH STIGMA AND DISCRIMINATION THEORETICAL FRAMEWORK:**  
**ANALYSIS AND EVALUATION**

This manuscript was published in the *Journal of Nursing Doctoral Student Scholarship*, a peer-reviewed publication of the University of Pennsylvania, in December 2023. It is formatted according to 7<sup>th</sup> edition American Psychological Association (APA) guidelines.

## **Abstract**

The Health Stigma and Discrimination Framework (HSDF) was developed to recognize and stop health-related stigma, or to minimize the negative health outcomes associated with health-related stigma and discrimination by creating an organized theoretical framework to guide research, intervention development and measurement, and social and healthcare policy. The purpose of this article is to deliver an analysis and evaluation of the HSDF as a middle range nursing theory. Theory analysis follows Walker and Avant's (2018) six steps in theory analysis, and theory evaluation applies Peterson and Bredow's (2019) middle range theory evaluation process. Empirical research provides evidentiary support of the usefulness and significance of the HSDF. Benefits of the framework are discussed including conceptual clarity, robust relational consistency between concepts, and overall usefulness. Implications for future research are suggested, including applying the HSDF to a wider range of health conditions and attaining a stronger presence in health-related databases to promote utilization.

## **Keywords/Phrases**

Health Stigma and Discrimination Framework, stigma, discrimination, health-related stigma, stereotype, drivers, facilitators, analysis, evaluation, middle range theory, middle range nursing theory, theoretical framework

## **The Health Stigma and Discrimination Theoretical Framework: Analysis and Evaluation**

A fundamental tenet of healthcare is that all patients deserve equal treatment regardless of individual characteristics or health conditions. Health-related stigma and discrimination negate this central principle because people who are stigmatized or discriminated against may feel as though they do not receive equal and unbiased care. In his groundbreaking book, Erving Goffman identified stigma as a personal or group attribute labeled as less worthy, less valuable, or different (Goffman, 1963). The worth of the attribute is questioned or lessened when it is stigmatized, and the effects of stigma can be broad and long-lasting. Discrimination is derived from stigma and essentially is treating someone or a group of people differently from others (Merriam-Webster, 2021). It is a social construct of unfair treatment that can result in negative health outcomes (Office of Disease Prevention and Health Promotion, n.d.).

Health-related stigma is the product of labeling human differences, and the level of stigmatization towards a health condition is based on the social significance of that health condition. Stereotyping occurs when a person or group of people are marked with one or more unfavorable characteristic connected to a health condition, and stereotyping is a key element of health-related stigma (Link & Phelan, 2006). The terms stigma and stereotype tend to be used interchangeably, but health-related stigma includes the concurrent incidences of stereotyping, labeling, and discrimination (Link & Phelan, 2001). Stangl and colleagues (2019) developed the Health Stigma and Discrimination Framework (HSDF) with the overarching goal to recognize and stop health-related stigma, or to minimize the negative health outcomes associated with health-related stigma and discrimination by creating an organized theoretical framework to guide research, intervention development and measurement, and social and healthcare policy.

The purpose of this article is to deliver an analysis and evaluation of the HSDF when used as a middle range nursing theory. Middle range theories are derived from overarching abstract grand theories and are operationalized to influence nursing practice in academic and clinical settings, yet they are not limited to a specific clinical situation. Therefore, middle range theories are practical for both nursing research and practice (Peterson & Bredow, 2019). Theory analysis will follow Walker and Avant's (2018) six steps in theory analysis, and theory evaluation will apply Peterson and Bredow's (2019) middle range theory evaluation process. These processes for analysis and evaluation were selected because of their relevance in and applicability to current nursing science.

## **Background**

The HSDF is deduced from previous theoretical and conceptual frameworks related to stigma associated with one health condition. Historically, health-related stigma has related to a certain stereotyped health condition like HIV/AIDS, obesity/overweight, and mental health issues, and the available frameworks were linked to a specific health condition (i.e., the Mental Illness Stigma Framework and the Cyclic Obesity/Weight-Based Stigma model) (Stangl et al., 2019). Desiring a broader and more encompassing framework to apply across all health conditions, Stangl et al. (2019) began developing the HSDF after a 2017 stigma research and global health workshop organized by the Fogarty International Center and through analysis of over twenty previous research studies and empirical articles. As a newer theoretical framework, the HSDF has yet to be analyzed and evaluated from a nursing perspective based on its core concepts, organization, and empirical support. Examining the HSDF from a nursing perspective is important because nurses generally spend the most time with patients during hospitalization (Shreffler et al., 2021) and evidence shows that patients have experienced disparate treatment

because of a health condition (Jaiteh et al., 2019). Nursing researchers currently assess for illness-related stigma through the use of specific measurement tools (i.e., the Perception of Opioid Use Survey and the Alcohol and Alcohol Problems Perception Questionnaire) but a knowledge gap remains related to general health-related stigma, how to stop it, and ways to prevent it in the future.

The authors of the HSDF hail from North America, Europe, and South Africa and have accomplished backgrounds in public health, psychology, social work, medicine, epidemiology, and social policy. Their work spans the globe and their contributions to combating health-related stigma is useful and applicable to people across all cultures. While none of the authors have a nursing background, the work they created is applicable to a range of health conditions; therefore, it is applicable to nursing practice, intervention, and research.

## **Theory Analysis**

Nursing theory analysis involves a methodical investigation of the theory to reach understanding (Walker & Avant, 2018). Utilizing Walker and Avant's (2018) six steps in theory analysis, this paper will explore the following areas of the HSDF: the origins of the theory, the meaning of the theory, the logical adequacy of the theory, the usefulness of the theory, the generalizability and parsimony of the theory, and finally, the testability of the theory.

### ***Origins***

The genesis of the HSDF is deduced from past stigma-related theoretical and conceptual frameworks focusing on one health condition at a time. The narrower focus of these past frameworks limits their generalizability, and thus, their potential influence. Stangl et al. (2019) developed the HSDF to guide intervention and research of a variety of health conditions like epilepsy, leprosy, and cancer to compare findings, analyze results, and implement evidence-based

change across health conditions and patient populations. Furthermore, while past theoretical frameworks explored health conditions at the individual level, the HSDF explores the psychological components of health-related stigma on the individual level as well as the social and structural levels which include cultural influences, gender norms, the legal environment, and associated health policy practices (Stangl et al., 2019).

### ***Meaning***

The meaning of a theory is derived from its concepts and their definitions, relational statements made about the concepts, and the boundaries of the theory (Walker & Avant, 2018). After careful analysis of these three components, empirical support for the meaning of the theory will be assessed using current and relevant research incorporating and utilizing the HSDF.

**Concepts.** Concepts are considered primitive, concrete, or abstract, and definitions are classified as either theoretical, operational, descriptive, or non-existent (Walker & Avant, 2018). The HSDF includes the following primary concepts (see Table 2) and secondary concepts (see Table 3) organized in three domains: drivers, facilitators, stigma marking, stigma manifestations (primary concepts); intersecting stigma, stigma experiences, experienced discrimination, experienced stigma, internalized stigma ('self-stigma'), perceived stigma, anticipated stigma, secondary (associative) stigma, and stigma practices (secondary concepts). The first domain includes the drivers and facilitators of stigma (Stangl et al., 2019). Drivers cause or enable health-related stigma and are fundamentally negative. Facilitators influence stigma and can be positive or negative. Drivers and facilitators have the potential to result in the second domain of the HSDF, stigma marking, in which stigma is linked to individuals or groups because of a health condition or a perceived difference (Stangl et al., 2019). Through a single or intersecting stigma (marking with more than one stigma including stigmas unrelated to health, such as gender,

**Table 2***Health Stigma and Discrimination Framework primary concepts and definitions*

| <b>Concept</b>        | <b>Type of Concept</b> | <b>Definition</b>                                                                                                                                | <b>Classification</b>                     |
|-----------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| Drivers               | Abstract               | Fundamentally negative factors that drive or enable health-related stigma.                                                                       | Theoretical                               |
| Facilitators          | Concrete               | Positive or negative influences on health-related stigmas.                                                                                       | Operational                               |
| Stigma marking        | Concrete               | Resulting from drivers and facilitators, stigma is linked to individuals or groups because of a health condition or other perceived differences. | Operational                               |
| Stigma manifestations | Concrete and abstract  | Stigma experiences and practices (see table 2).                                                                                                  | Theoretical, operational, and descriptive |

**Table 3***Health Stigma and Discrimination Framework secondary concepts and definitions*

| <b>Concept</b>                         | <b>Type of Concept</b> | <b>Definition</b>                                                                                                                                           | <b>Classification</b>                     |
|----------------------------------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| Intersecting stigma                    | Concrete and abstract  | Stigma marking with multiple stigmas including stigmas unrelated to health.                                                                                 | Theoretical, operational, and descriptive |
| Stigma experiences                     | Concrete and abstract  | Includes experienced discrimination, experienced stigma, internalized (self-) stigma, perceived stigma, anticipated stigma, secondary (associative) stigma. | Operational and descriptive               |
| Experienced discrimination             | Concrete               | Stigmatizing behaviors that carry legal repercussions for the responsible individual(s).                                                                    | Operational                               |
| Experienced stigma                     | Concrete and abstract  | Stigmatizing behaviors that do not carry legal repercussions for the responsible individual(s).                                                             | Descriptive                               |
| Internalized stigma or ‘self-stigma’   | Abstract               | The acceptance of stigmatizing traits.                                                                                                                      | Theoretical                               |
| Perceived stigma                       | Abstract               | Assumptions of how a stigmatized individual(s) will be treated in a certain situation.                                                                      | Theoretical                               |
| Anticipated stigma                     | Abstract               | Expectation of stigmatization based on a certain health condition(s).                                                                                       | Theoretical                               |
| Secondary stigma or associative stigma | Concrete and abstract  | Family or friends of stigmatized individuals(s) experiencing stigma themselves.                                                                             | Theoretical and operational               |

**Table 3 continued**

| <b>Concept</b>   | <b>Type of Concept</b> | <b>Definition</b>                                                                                                        | <b>Classification</b>       |
|------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Stigma practices | Concrete and abstract  | Stereotyping (also a Driver), prejudicial behavior (also a Driver), stigmatizing behavior, and discriminatory attitudes. | Theoretical and operational |

occupation, and sexual orientation), stigma manifestations occur in the form of stigma practices or experiences. This delineates the third domain of the HSDF. Stigma manifestations have the potential to impact health and social outcomes for individuals and groups (Stangl et al., 2019).

The concepts included in the HSDF are clearly and thoroughly defined. More importantly, the use of the concepts and their meanings are consistent throughout the framework (Walker & Avant, 2018). The HSDF is used in research to predict and understand potential outcomes to people and populations experiencing stigma, to organizations and institutions related to health, and more generally to the health and social impacts that stigma can have on overall quality of life, morbidity, and mortality (Stangl et al., 2019).

**Relational Statements.** Relationships between concepts should be present and consistent throughout a theoretical framework, and relational statements will elucidate these correlations. Causal relationships exist when one concept causes another. Associational relationships exist when two or more concepts are related in either a positive, negative, or unknown way (Walker & Avant, 2018). A positive associational relationship is one where concepts change together, and a negative associational relationship occurs when concepts change inversely or opposite of each other (Walker & Avant, 2018). With the HSDF, drivers and facilitators have causal relationships with stigma marking and manifestations; drivers and facilitators cause stigma marking and stigma manifestations. Stigma experiences result from drivers, facilitators, and stigma marking, and each stigma experience can have a positive or negative association with each other based on the situation (Stangl et al., 2019). Stigma practices can have a positive or negative association with drivers and facilitators again, based on the situation. Stangl et al. (2019) consistently apply conceptual terms throughout the HSDF; therefore, concept and relational clarity is ever-present.

**Boundaries.** The HSDF serves as a middle range theory because it contains practice-level implications without being limited to one diagnosis, population, or discipline. The authors of the theoretical framework intend it for use across disciplines and cultures to standardize measures and procedures, compare results and outcomes across illnesses and fields, and plan interventions that are more effective for the general population rather than for those suffering a certain health condition (Stangl et al., 2019).

**Empirical Support.** Six articles were identified when determining empirical support for the HSDF (see Table 4). One article was co-written by an author of the seminal HSDF report (Carmen H. Logie), and five articles were written by other authors. Three articles employed qualitative designs to explore the relationships between stigma and HIV/AIDS or people living with HIV/AIDS (PLWHA) (Fauk et al., 2021; Ferraz et al., 2019; and Logie et al., 2021). One report explored COVID-19 related stigma and discrimination (Ransing et al., 2021). Finally, two articles aimed to systematically review literature concerned with health-related stigmas. One was a scoping review meant to reveal what is known about human papilloma virus (HPV) infection and vaccination stigmas as well as cervical cancer and screening related stigmas (Peterson et al., 2021). The last and most recent article proposed a protocol to guide systematic review of current literature related to stigmatized conditions in migrant and minority groups based on the HSDF (Douglass et al., 2022).

Fauk et al. (2021) aimed to describe the viewpoints and personal experiences of health care providers caring for people living with HIV/AIDS (PLWHA) in Indonesia. The team conducted one-on-one in-depth interviews with 112 participants, 92 PLWHA and 20 health care workers. The HSDF is used to abstract study findings and the structure and central themes of the theoretical framework is supported throughout the study. Conceptual clarity is present from

**Table 4***Research studies used when determining empirical support of the HSDF*

| <b>Author<br/>(Year)</b>  | <b>Purpose</b>                                                                                                                                                                                                 | <b>Sample</b>                                                                                             | <b>Concepts</b>                                                                                                                                                                                                                                                                          | <b>Analytic Technique</b>                                                                                 | <b>Result</b>                                                                                                                                                                |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Douglass et al.<br>(2022) | To critically appraise and synthesize qualitative research to reveal how stigma associated with mental health conditions and alcohol and other drug (AOD) use affects people from migrant and minority groups. | N/A – this article offers a protocol to guide a systematic review of literature using the HSDF as a guide | Drivers<br>Facilitators<br>Intersecting stigma<br>Mental health conditions<br>Alcohol and other drug use (AOD)<br>Stigma marking<br>Stigma manifestations<br>Stigma experiences<br>Stigma practices<br>PRISMA-P<br>Internalized stigma<br>Intersectionality<br>Habitus<br>Symbolic power | Critical appraisal using the Joanna Briggs Institute Critical Appraisal Checklist for qualitative studies | The HSDF is appropriately utilized in the creation of a protocol to guide a systematic review.<br><br>Key concepts and relational terms are consistent throughout the piece. |

**Table 4 continued**

| <b>Author<br/>(Year)</b> | <b>Purpose</b>                                                                                                               | <b>Sample</b>                                                                         | <b>Concepts</b>                                                                                                                                                                                                                                       | <b>Analytic<br/>Technique</b>                                                                                                                             | <b>Result</b>                                                                                                                                                                                                                                                                                                                                     |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Fauk et al.<br>(2021)    | To describe the perspectives and personal experiences of healthcare providers caring for people living with HIV/AIDS (PLWHA) | Indonesia<br>N=112<br>92 participants living with HIV/AIDS<br>20 healthcare providers | Health stigma<br>Discrimination<br>Drivers<br>Facilitators<br>Stigma marking<br>Prejudice<br>Stigma manifestations<br>Negative labeling<br>Separation of personal belongings<br>Avoidance<br>Denial of treatment<br>Rejection of PLWHA<br>Stereotypes | One-on-one in-depth interviews for data collection<br><br>Data analysis was guided by Ritchie & Spencer's (1994) analysis framework for qualitative data. | The HSDF is used to abstract study findings and the study supports the structure and central themes of the HSDF.<br><br>Drivers and facilitators are identified and clearly elucidated according to their function.<br><br>Stigma marking and manifestations are appropriately utilized and aid in the conceptualization of the themes presented. |

Table 4 continued

| Author (Year)        | Purpose                                                                                                                                           | Sample                                                                      | Concepts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Analytic Technique                                                                                                                                                                                                                                                    | Result                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ferraz et al. (2019) | To explore how AIDS-related stigma affects the experience of using non-occupational post-exposure prophylaxis (nPEP) for HIV after sexual contact | Brazil<br>N=59<br>59 HIV-negative participants that voluntarily sought nPEP | AIDS-related stigma<br>Antiretroviral drugs (ARVs)<br>Pre-exposure prophylaxis (PrEP)<br>Non-occupational post-exposure prophylaxis (nPEP)<br>Stigma associated with living with HIV<br>Stigma associated with belonging to a sexual minority<br>Stigma associated with sex work<br>Drivers<br>Facilitators<br>Stigma marking<br>Stigma experiences<br>Stigma manifestations<br>Stigma outcomes<br>Experienced discrimination<br>Internalized stigma<br>Perceived stigma<br>Anticipated stigma<br>Stigma practices<br>Stereotypes<br>Prejudice<br>Discriminatory attitudes | Semi-structured in-depth interviews for data collection<br><br>Interviews were recorded, transcribed, and reviewed by a researcher.<br>Thematic analysis was performed and resulted in three categories of how stigma influenced participants' experiences with nPEP. | Thematic analysis revealed three categories of how stigma influenced participants' experience with nPEP: 1. Fear of being mistaken for a person living with HIV-AIDS (PLWHA); 2. The desire to keep certain facts of sexual life confidential; and 3. Lived experiences of stigma marking resulting from the use of nPEP.<br><br>The HSDF was appropriately utilized, and the results of the study fully satisfy the flow of drivers and facilitators through stigma marking, experiences, manifestations, to social and health outcomes.<br><br>Experienced discrimination was not consistently linked with legal ramifications related to discrimination, so experienced stigma may have been more appropriate there. They define experienced discrimination as 'one's suffering stigmatizing behaviors' (p. 110). |

Table 4 continued

| Author<br>(Year)       | Purpose                                                                                                        | Sample                             | Concepts                           | Analytic<br>Technique                                                                                                                                                                                                             | Result                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Logie et al.<br>(2021) | To explore experiences and perspectives toward HIV testing, including HIV self-testing, in urban refugee youth | Uganda                             | Stigma processes                   | Five focus group sessions with refugee youth                                                                                                                                                                                      | The HSDF informs this study to reveal specific drivers and facilitators related to HIV testing in refugee youth.                                                                                                                                                                                                                                                                                                              |
|                        |                                                                                                                | N=49                               | Perceived or felt-normative stigma |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                        |                                                                                                                | 44 refugee youth participants      | Enacted stigma                     |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                        |                                                                                                                | 5 key informant group participants | Internalized or self-stigma        | Five interviews with key informants from government, non-government, and community-based refugee agencies, as well as HIV care providers in the refugee community                                                                 | Stigma drivers and facilitators result in the study findings. Drivers include attitudes and beliefs that perpetuate vulnerability (misinformation that HIV only happens to some people), fear of testing positive for HIV, and blame and shame for sexual activity. Facilitators include confidentiality concerns as well as legal, institutional, and community influences that support HIV prevention or increase HIV risk. |
|                        |                                                                                                                |                                    | Drivers                            |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                        |                                                                                                                |                                    | Facilitators                       |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                        |                                                                                                                |                                    | Stigma experiences                 |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                        |                                                                                                                |                                    | Intersecting stigma                | Interviews and focus groups were conducted in native languages and then translated and transcribed in English. Transcripts were coded using NVIVO software, inductive and deductive themes were exposed during thematic analysis. | Drivers and facilitators are clearly differentiated.                                                                                                                                                                                                                                                                                                                                                                          |

**Table 4 continued**

| <b>Author<br/>(Year)</b> | <b>Purpose</b>                                                                                                                            | <b>Sample</b>                                                                                                                      | <b>Concepts</b>                                                                                                                                                                                                | <b>Analytic<br/>Technique</b>                                | <b>Result</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Peterson et al. (2021)   | A scoping review to determine what is known about stigma associated with HPV infection and vaccination, and cervical cancer and screening | USA<br><br>14 research papers                                                                                                      | Drivers<br>Positive facilitators<br>Negative facilitators<br>Stigma marking<br>Stigma practices<br>Stereotyping<br>Prejudice<br>Stigma experiences<br>Stigma manifestations<br>Perceived or anticipated stigma | Themes revealed in the review are presented using PRISMA ScR | Major concepts in the three domains of the HSDF were supported and consistently applied throughout this scoping review.                                                                                                                                                                                                                                                                                                                  |
| Ransing et al. (2020)    | To explore COVID-19 related stigma (COS) and discrimination                                                                               | 13 countries<br><br>No sample, this is a descriptive letter based on the real-life experiences of psychiatrists from 13 countries. | Drivers<br>Facilitators<br>Intersecting stigma<br>Stigma experiences<br>Stigma practices<br>Secondary or associative stigma<br>COVID-19 related stigma (COS)                                                   | None                                                         | This descriptive article echoes the findings of previous studies and the central tenets of the HSDF. The HSDF is utilized appropriately; drivers and facilitators cause stigma marking, manifestations, and outcomes that have major health and social impacts.<br><br>Drivers include fear, beliefs, and blame. Facilitators include social inequalities, beliefs, lack of regulation, and social media use along with media influence. |

beginning to end. The authors address each primary and secondary concept within the HSDF, and special consideration is given to the drivers and facilitators of stigma marking which include a lack of understanding of HIV as well as fear associated with HIV, specifically the fear of contracting HIV through physical contact and the fear of social repercussions of associating with PLWHA. Stigma marking and manifestations are appropriately described, and these descriptions aid in the conceptualization of the themes presented. Stigma marking is placed on PLWHA because of their health condition. Stigma manifestations include stereotypes assuming to reflect the beliefs of PLWHA and prejudice against PLWHA in the form of anger, disgust, and fear (Fauk et al., 2021).

In their 2019 research study, Ferraz et al. conducted semi-structured in-depth interviews to explore how AIDS-related stigma affects the decision to use non-occupational post-exposure prophylaxis (nPEP) for HIV after sexual contact. The study included 59 HIV-negative participants in Brazil who voluntarily sought nPEP treatment. Thematic analysis revealed three categories of how stigma influenced participants' experience with nPEP: 1. fear of being incorrectly labeled a person living with HIV/AIDS (PLWHA); 2. the wish to keep certain facts of private life confidential; and 3. lived experiences of stigma marking resulting from the use of nPEP (Ferraz et al., 2019). The HSDF is logically used throughout the study, and results satisfy the prescribed flow of drivers (fear of infection and revealing sexual behaviors) and facilitators (availability of and access to nPEP) through stigma marking (AIDS-, sexuality-, and gender-related stigmas), experiences (fear of being labeled a PLWHA and facing stigma because of sexual identity and practices), and manifestations (facing stigma in health care settings and sex work experiences and being prejudicially labeled as risky to sexual partners) to social and health outcomes (continuing inadequate knowledge of nPEP and decreased quality of life and social

confidence during nPEP use) (Ferraz et al., 2019). Conceptual clarity is consistent with the original framework with one exception: experienced discrimination as described in this study is not obviously linked with legal ramifications related to discrimination. Because Stangl et al. (2019) clearly differentiate the two concepts- experienced discrimination includes stigmatizing behaviors that carry legal repercussions for the responsible individual(s), and experienced stigma includes stigmatizing behaviors that do not carry legal repercussions for the responsible individual(s), the concept of experienced stigma would be more appropriate than experienced discrimination for use in this study.

Logie and colleagues (2021) conducted a qualitative study to explore lived experiences and perspectives of HIV testing in refugee youth living in Uganda. Data were collected through focus group sessions with the youth and through interviews with key informants from refugee agencies as well as HIV care providers in the refugee community. Concepts are clearly defined, and relational statements are consistent throughout the study and with the original theoretical framework. The HSDF informs the research and specific drivers and facilitators related to HIV testing in refugee youth are revealed. Drivers include attitudes and beliefs that perpetuate vulnerability (misinformation that HIV only happens to some people), fear of testing positive for HIV, and blame and shame for sexual activity. Facilitators include confidentiality concerns as well as legal, institutional, and community influences that support HIV prevention or increase HIV risk (Logie et al., 2021). While some studies combine drivers and facilitators as overlapping concepts, the authors of this study clearly differentiate drivers and facilitators which enhances the understanding of and relationships between the concepts.

In their 2020 report, Ransing and colleagues elucidated real-life experiences of psychiatrists from 13 countries. Their investigation echoes the findings of the three previous

studies related to stigma and the central tenets of the HSDF. Ransing et al. (2020) utilize the HSDF to explore COVID-19 related stigma experienced by their patients; drivers and facilitators cause stigma marking, manifestations, and outcomes that have major health and social impacts. Drivers include fear, beliefs, and blame. Facilitators comprise social inequalities, beliefs, lack of regulation, and social media use along with media influence. A flaw in this report is the methods for data collection and data analysis are never discussed which weakens the empirical support of the source.

Peterson et al. (2021) undertook a scoping review to identify what is known about stigma related to human papilloma virus (HPV) infection, HPV vaccination, cervical cancer, and cervical cancer screening. After application of inclusion and exclusion criteria, the team reviewed 14 research papers (eight qualitative, four quantitative, one mixed-method, and one from data acquired from a blog post) and utilized the Preferred Reporting Items for Systematic Review and Meta-Analyses Extension for Scoping Review (PRISMA ScR) checklist to present themes and concepts. The primary and secondary concepts in the three domains of the HSDF were supported and consistently used throughout the scoping review. Stigma marking was the most common concept extracted from the review (13/14 articles included stigma marking), and stigma experiences was the least common concept extracted (4/14 articles) (Peterson et al., 2021). The authors succeed in detailing the concepts and conceptual relationships in the first three domains of the framework (1. drivers and facilitators, 2. stigma marking, 3. stigma manifestations). While not described as part of the HSDF within the review, the outcomes as well as social and health impacts of health-related stigma are identified at the beginning of and throughout the study: HPV infection, cervical cancer, HPV vaccination, and cervical cancer screening (Peterson et al., 2021).

Most recently, Douglass et al. (2022) developed a protocol informed by the HSDF to guide a systematic review of literature related to stigma associated with mental health conditions and alcohol and other drug use in people from migrant and minority groups. The HSDF is appropriately utilized in the creation of the protocol. Key concepts and relational terms are consistent throughout. The results of this systematic review cannot be analyzed as the review has not yet occurred or been published, but the organizational framework for the review is aligned with the prescribed structure of the HSDF.

### ***Logical Adequacy***

Determining the logical adequacy of a theory is complex and specific to linguistic philosophy (Walker & Avant, 2018). Because this is an analysis of a middle range theory useful in nursing, it will focus on four specific components of logical adequacy: 1. predictions made from the theory independent of content, 2. agreement of scientists on the predictions, 3. coherence of the theory among scientists, and 4. the presence of any logical fallacies (Walker & Avant, 2018).

Based on Stangl and colleague's (2019) seminal work and supported with empirical evidence by six groups of scientists in the past four years, predictions can be made from the HSDF independent of the content of each study. Drivers and facilitators lead to stigma marking. Stigma marking with one health-related stigma can lead to stigma manifestations, or marking with intersecting stigmas (additional stigmas including stigmas unrelated to health, such as gender, occupation, and sexual orientation) can result in stigma manifestations. Manifestations include stigma experiences for those being stigmatized and stigma practices from those imparting the stigma as well as those experiencing it. When manifestations such as experienced stigma and discrimination and prejudicial practices result, health-related outcomes can follow.

Outcomes connected to the stigmatized population include diminished legal justice, altered access to health care services including primary level health care, less adherence to medical treatment, and decreased resilience and advocacy in the affected individual or population (Stangl et al., 2019). Along with affecting stigmatized populations, stigma manifestations can affect outcomes for organizations and institutions such as law enforcement practices, laws and policies, the accessibility of quality health services, and social protections (Stangl et al., 2019). These outcomes have the potential to culminate in general health and social impacts that can jeopardize quality of life and increase morbidity, mortality, and the incidence of negative health experiences (Stangl et al., 2019).

The format of the HSDF remains consistent throughout its use, from its origination through the empirical evidence analyzed for this report. In the six articles reviewed for this analysis, scientists use the HSDF as intended to make predictions about the theory and the content of their research. No outliers or opposing views to the structure or use of the theoretical framework were identified, and no obvious modifications have been made to the originally proposed framework.

Analysis revealed no obvious logical fallacies in the original framework or the evidentiary articles utilizing and supporting the framework. Walker and Avant (2018) explain that deductive logical fallacies occur when the premises on which the theory is based do not match with the conclusion(s) of the newer theory. Stangl et al.'s (2019) HSDF is based on previous stigma research, conceptual frameworks, and theoretical frameworks related to a single health condition or attribute and it is deduced from this research to form the current framework. The premises on which the HSDF is based align with the current format; therefore, logical

adequacy is achieved. Furthermore, subsequent literature using the HSDF as a theoretical basis applied the framework in its original form with no major modifications or revisions.

### ***Usefulness***

Usefulness of a theory is determined by whether it significantly enhances a scientific knowledge base (Walker & Avant, 2018). The HSDF has generated several research studies since its inception just three years ago. The theory is relevant to a wide range of individuals and situations which is the major difference between it and related historical frameworks. Instead of focusing on stigma and discrimination related to a single health condition on one side of the stigma equation, the HSDF is applicable to both the *stigmatizer* (the one placing stigma on another or on a health condition) and *stigmatizee* (the one being stigmatized) at once, without emphasizing this dichotomy, across a wide range of health conditions and situations (Stangl et al., 2019).

Finally, the HSDF has the potential to influence not only nursing practice, education, research, and administration, but also general health and policy related practice, education, research, and administration. Understanding the relationships between health-related stigma and health and social outcomes at the individual and community levels can empower providers, researchers, and lawmakers to focus on the root causes of health-related stigma and discrimination in order to combat it at the health care delivery level. The general transcultural applicability of the HSDF to human caring, intervention, and evidence-based improvement makes it extremely useful to the global health care community by providing a clear description of the path that health-related stigma and discrimination can take to potentially influence health outcomes.

### ***Generalizability and Parsimony***

Generalizability refers to how broadly a theory can be used in explaining a phenomenon based on the boundaries and empirical support of the theory (Walker and Avant, 2018). As detailed previously, the HSDF can function as a middle range theory because it contains practice-level implications without being limited to one diagnosis, population, or discipline. The authors of the theoretical framework intend it to be applied broadly for use across disciplines and health conditions (Stangl et al., 2019). The HSDF has the potential to be widely generalizable; however, it has not met that potential yet based on use in current literature. Of the six articles reviewed for this analysis, half were related to HIV/AIDS. Scientists should utilize the HSDF when studying stigma related a range of health conditions instead of just traditionally stigmatized health conditions. When this is achieved, the HSDF will be more generalizable. Additionally, the empirical evidence provided in this analysis was generated from qualitative research and literature which inherently limits its generalizability. Quantitative research should be informed by the HSDF to yield reproducible studies that generate solid results and knowledge.

Parsimony is achieved when a theory is explained simply and concisely without losing the detailed structure or completeness of the theory (Walker & Avant, 2018). In the introductory HSDF article, Stangl et al. (2019) define the concepts, describe the relationships between concepts, and diagram the conceptual flow through the framework simply and without superfluous explanation. Empirical support of parsimony is evident in the literature reviewed for this analysis. Scientists utilized the HSDF as intended to define and relate the health conditions and social situations under study and the result is clear, concise, and aligned with the central flow of the HSDF. No revisions or modifications to the original HSDF published in 2019 were found which strengthens the argument that the framework is parsimonious.

### ***Testability***

Walker and Avant (2018) opine for a theory to be accepted and accurately utilized, it must be testable. Testability is supported with empirical evidence of hypothesis generation and testing which leads to theory validation or modification (Walker & Avant, 2018). The HSDF has not reached full testability at this time for several reasons. It is a newer theoretical framework originating in 2019, and it has been utilized in qualitative studies focusing on already highly stigmatized health conditions which limits its generalizability. Furthermore, the HSDF is difficult to find in databases and online when searching for research-based nursing theoretical frameworks. Increased availability and awareness of the HSDF, along with using it in structured quantitative research will make it more useful in future research which will increase its testability.

### **Theory Evaluation**

While the purpose of theory analysis is to reach understanding, the purpose of theory evaluation is to make a decision about the theory that could possibly lead to action (Walker & Avant, 2018). This section will utilize Peterson and Bredow's (2019) middle range theory evaluation process which incorporates several elements of internal criticism and external criticism to evaluate the HSDF.

### ***Internal Criticism***

Internal criticism of a theory includes evaluating the adequacy, clarity, consistency, and logical development of a theory as well as the level of theory development (Peterson & Bredow, 2019). The HSDF addresses the topics of stigma and discrimination in health care and relates these topics to general social health outcomes. The concepts used to build the theory are clearly defined and are plainly related to one another throughout the framework. Conceptual meaning

and relational statements are consistent from the original framework and throughout the six articles reviewed for this evaluation. Stangl et al. (2019) build on previous scientific literature to deliver an innovative theoretical framework to guide intervention and research across a variety of health conditions from the perspective of the causes and effects of health-related stigma rather than the dichotomous perspective of either those perpetuating health-related stigma or those experiencing health-related stigma. Because the HSDF is useful to a range of disciplines and health conditions, the practice level utility of the framework extends beyond empirical theory to middle range theory in that it applies to general health-related stigma rather than stigma associated with one health condition.

### ***External Criticism***

External criticism of a theory encompasses several elements of evaluation including the theory's complexity, level of discrimination, reality convergence, pragmatism, scope, significance, and utility (Peterson & Bredow, 2019). The HSDF incorporates four primary concepts and nine secondary concepts derived and extended from the primary concepts. These concepts are clearly defined and consistently used throughout the theory. Furthermore, empirical evidence confirms the consistent nature of the concepts across a range of research studies. Because Stangl and colleagues (2019) achieve parsimony with the framework, the HSDF is appropriately complex.

The level of discrimination evident in the HSDF is ambiguous. Further research is needed to determine if the HSDF alone can produce hypotheses and results that could not be met utilizing other nursing theories (Peterson & Bredow, 2019). Reality convergence is achieved by the HSDF because the theory's underlying assumptions represent the real world and real-life situations. Health-related and illness-related stigma and discrimination are present hurdles in

today's world and the HSDF accurately and simply portrays these phenomena as understood by the general reader (Peterson & Bredow, 2019).

The HSDF is pragmatic because it can be utilized in the real world (Peterson & Bredow, 2019) as evidenced by the empirical support presented in this paper. The scope of the HSDF is a continuum from practice-level implications to global ideology; however, it is most consistently applied in middle range research. The HSDF displays preliminary real-world utility because it is useful to nurses in research and problem solving in practice, and this utility will be strengthened when the theory is supported through quantitative research studies contributing to hypothesis building (Peterson & Bredow, 2019).

## **Conclusion**

Stangl et al. (2019) developed the HSDF to guide intervention and research of a variety of health conditions with the ability to compare findings, analyze results, and implement evidence-based change across health conditions and patient populations. The purpose of HSDF utilization is to recognize and stop health-related stigma, or to minimize potential negative health outcomes associated with health-related stigma and discrimination. The HSDF is a valuable guide for transcultural scholars and practitioners because it can influence a variety of stigma research. The results and implications of such research can inform how health care practitioners care for individuals that suffer from traditionally stigmatized health conditions with the overall goal to improve health outcomes.

Future health-related stigma research should utilize the HSDF across health conditions and populations. The HSDF can be generalized to relate to a variety of illnesses, social and cultural groups, and political causes while functioning and guiding specific interventions at the practice level. Interestingly, half of the articles reviewed for empirical support (3 of 6) focused

on stigma related to HIV/AIDS, and these three articles were the only research studies in the group. A central tenet of the HSDF is its applicability across a range of health conditions; therefore, future research should focus on a variety of health conditions to expand the influence of the HSDF beyond traditionally stigmatized health conditions.

Further research and work utilizing the HSDF is necessary to strengthen its benefits and usefulness as well as to modify and enhance it as needed. Quantitative research is needed to determine if the HSDF alone can produce hypotheses and results that could not be met utilizing other nursing theories which would help to measure the level of discrimination (Peterson & Bredow, 2019). To further testability, the HSDF needs a greater presence in health-related databases, and this will be achieved by increased use and scrutiny.

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**CHAPTER IV**  
**STIGMATIZING PATIENTS WITH OPIOID USE DISORDER: FACTORS**  
**CONTRIBUTING TO THE PROVISION OF EQUITABLE NURSING CARE**

This manuscript has been formatted according to the author guidelines of the *Online Journal of Issues in Nursing (OJIN)*, a scholarly, peer-reviewed publication of the American Nurses Association. It will be submitted to *OJIN* for publication. This manuscript follows the 7<sup>th</sup> edition American Psychological Association (APA) formatting guidelines. Dr. Cristina Barroso, Cary Springer, Dr. Nan Gaylord, Dr. Jennifer Miller, and Dr. Shandra Forrest-Bank will be co-authors on this manuscript.

## **Abstract**

Stigmatizing patients with opioid use disorder (OUD) negatively affects patients' health outcomes and quality of life, and it has harmful effects on families and communities. It contributes to unemployment and housing disruption which may place those with OUD on a dangerous cycle that is hard to overcome. Nurses have a responsibility to provide equal, holistic care to all patients with all health conditions. Many nurses successfully provide equitable care. However, some nurses fall short, and some nurses may not realize they are providing disparate care. This study was conducted to examine the relationships between nurses' perceptions of their abilities to provide equitable care to those with and without OUD and education level, experience in nursing, age, gender, social attitudes, and personal experiences. Data from the 2022 Perception of Opioid Use Survey was analyzed in this cross-sectional secondary analysis. Age, experience in nursing, and two social attitudes were found to have significant relationships with nurses' perceptions of equitable care. In fact, age is a predictor of perceptions of equitable care, and future research should explore other contributors to the provision of equitable care.

## **Keywords/Phrases**

Stigma, health-related stigma, nurse, nursing, discriminative nursing care, opioid, opioid use disorder, OUD, substance use disorder, Health Stigma and Discrimination Framework, Perception of Opioid Use Survey

## **Stigmatizing Patients with Opioid Use Disorder: Factors Contributing to the Provision of Equitable Nursing Care**

Stigmatizing patients because of a health condition or conditions can have deleterious effects on their physical, mental, and emotional health. Nurses are charged with providing unbiased, compassionate, and holistic care to all patients regardless of health conditions, and many nurses succeed in delivering such care. Unfortunately, some nurses provide discriminative nursing care (DNC) knowingly or unknowingly. DNC is the unequal treatment based on a health condition like an illness or disease, diagnosis, or comorbidity, or an associated attribute such as lifestyle, socio-demographic status, age, or personal choices (Bernier & Barroso, 2024). One highly stigmatized health condition is opioid use disorder (OUD) (Hawk et al., 2022), which is the chronic misuse of opioids that causes significant harm and ranges from opioid dependence to opioid addiction (Dydyk et al., 2024). OUD stigma and discrimination are harmful not only to those experiencing OUD, but also to their families, their communities, the health care system, and society as a whole.

### **Background**

Opioid use disorder (OUD) is a type of substance use disorder (SUD) affecting over 16 million people worldwide (Dydyk et al., 2024) from all cultural, educational, and socioeconomic backgrounds (Centers for Disease Control and Prevention [CDC], 2022). Many people with OUD receive hospital care and this care may be directly related to their OUD, or it may be for another issue unrelated to OUD. No matter whether someone's OUD is current or historical, people experiencing OUD have received disparate treatment during hospitalization compared to those without OUD. People with OUD are blamed for their disease and their behavior when taking opioids. They are stereotyped as being unpredictable and even dangerous (Yang et al.,

2018). Patients with OUD feel judged for their illnesses and comorbidities (Blair et al., 2021; Simon et al., 2020). They also report delays in care, poor communication with the health care team (Jaiteh et al., 2019), and inadequate pain control (Horner et al., 2019). Likewise, nurses have reported treating people with OUD generally unequally compared to people without OUD (El Rasheed et al., 2016). Specific disparate treatment according to nurses includes both insufficient pain control and spending an inadequate amount of time with patients with OUD (Horner et al., 2019). Clearly, stigmatization because of a health condition like OUD is a fundamental cause of health inequities (Earnshaw, 2021; Hatzenbuehler et al., 2013). It compromises health care (Horner et al., 2019) and can cause negative health outcomes resulting from delayed care and disparagement of pain and medical issues (Hawk et al., 2022).

Stigmatizing those with OUD has been linked to reduced quality of life (Earnshaw, 2021). While OUD stigma and discrimination can cause negative health outcomes, it can also cause social isolation, social rejection, and self-isolation. Support and social connections are essential when coping with OUD and succeeding through recovery, which is why social isolation can be particularly detrimental to those with OUD. Social isolation not only affects people with OUD, but it also affects their families (Sapp & Hooten, 2019) who may anticipate stigma from social interactions. This anticipated stigma could be too great to bear which causes families to resort to isolation rather than disclosing their family member's OUD (Earnshaw et al., 2019). This exacerbates the effects of self-isolation and could prevent any support from outside the home or family. Along with isolation from the outside world, those with OUD often face social rejection from family and friends, their core support system, and this rejection further exacerbates self-isolation (Earnshaw, 2021).

The effects of OUD stigma and discrimination not only reach those with OUD and their family members; it reaches the communities in which they live as well as the broader society. OUD stigmatization has downstream impacts on employment and housing. Employment policies commonly mandate drug testing, and a positive test result may affect hiring or continued employment (Earnshaw, 2021). Organizational policies may even block the opportunity for employment for people in recovery (Richardson & Epp, 2016). Because employment contributes to better recovery outcomes including remaining in recovery and abstaining from substance abuse (Earnshaw, 2021), blocking employment opportunities for those with or recovering from OUD impedes their recovery progress and further increases their risk for housing insecurity and disruption.

A key social determinant of health is housing, and OUD treatment is less effective when someone without housing is discharged after care (National Health Care for the Homeless Council [NHCHC], 2019). The link between OUD stigmatization and housing, however, is not one-directional; it is circular. For example, people with past or present drug use are often denied housing opportunities by housing agencies (Lopez & Reid, 2017). This perpetuates the cycle of disadvantages experienced by so many people with OUD. Housing disruption is linked to negative health and social outcomes including violence, malnutrition, exposure to infectious disease, developing or worsening substance use disorders, and even death (NHCHC, 2019). What this means is OUD treatment and health services are less effective when coupled with housing disruptions. OUD stigmatization can increase the prevalence of housing disruption, and housing disruption in and of itself causes negative health and social outcomes. This dangerous cycle can be almost impossible to disrupt for someone experiencing OUD.

## ***Problem***

An integrative review performed in 2022 analyzed and evaluated the current state of the science related to discriminative nursing care (DNC) practices towards patients with OUD in the hospital setting. The main theme emerging from this review was nurses' lack of understanding (Bernier & Barroso, 2024). Nurses lack the necessary opioid knowledge to care for patients with OUD holistically and equally. Accrediting organizations and benchmarking exams dictate nursing school curricula. Nurses who succeed in nursing school and pass the state licensure exam have met the standards set to deliver quality patient care, yet a lack in nurses' opioid knowledge persists. An exigent gap in providing equal care to those with and without OUD is accurately measuring nurses' opioid knowledge as well as their ability to fairly care for patients with and without OUD. While no objective measure to determine the ability to provide equitable care exists, nurses' perceptions of their abilities to provide equitable care can be measured.

## ***Perception of Opioid Use Survey***

The Perception of Opioid Use Survey (POUS) was developed to measure nurses' attitudes, knowledge, and practices towards patients using opioids, and it was piloted in 2020 at a large hospital system in the South Atlantic United States (Burton et al., 2021). The POUS was deemed reliable and valid through psychometric testing, but revisions were suggested to update selected terminology and to scale items in a more logical and congruent way. The survey was modified and implemented again in 2022 at the same health system. The 2022 survey was administered as a pre/post survey with a teaching intervention (Yearwood et al., 2024). The data analyzed for this study are the pre-intervention data.

The 2022 POUS contained twenty-two Likert-scale items (1 = disagree strongly; 2 = disagree moderately; 3 = disagree slightly; 4 = don't know; 5 = agree slightly; 6 = agree

moderately; 7 = agree strongly). Each item is scaled into one of four domains: self-efficacy, social attitudes, community impact, and causative factors (Yearwood et al., 2024). In terms of nurses caring for patients with opioid use and misuse, “self-efficacy” involves nurses’ beliefs, or perceptions, in their abilities to provide care to people with OUD. The domain “social attitudes” describes a subjective interpretation of nurses’ personal agreement with common social beliefs about OUD. “Community impact” describes the nurses’ beliefs about the effects of opioid use and misuse on their geographic and social communities. “Causative factors” encompass nurses’ beliefs about social and structural root causes of the opioid epidemic (Yearwood et al., 2024). Along with the twenty-two Likert-scale items, the 2022 POUS contained nine items on demographic data and other measures directly related to working as a nurse and experience with people using and misusing opioids. The last item on the survey sought to identify the opioid education most desirable to participants.

### **Operationalization of Independent Variables.**

To determine the data appropriate for analysis in this study, items of the 2022 POUS were studied, and literature germane to the topic of this research was reviewed. Because a lack of nursing knowledge was found to be a facilitator of OUD stigmatization in the 2022 integrative review driving this research, nursing knowledge was identified as a potential independent variable. Thus, the concept of nursing knowledge needed to be defined in measurable terms for data analysis. Nursing knowledge is an abstract concept that has been studied and debated over the past forty years by leaders in nursing practice, research, theory, and philosophy. Nursing knowledge is dynamic; it includes all the components needed to care for patients, and it is rooted in nursing practice. Additionally, nurses must be able to teach nursing knowledge to future nurses (Hall, 2005). Although nursing knowledge is often acquired from biological and social sciences,

it is the communication of this knowledge in the context of benefitting patients that is unique to nursing (Hall, 2005). The multidimensionality of the concept of nursing knowledge makes it difficult to define in terms of a variable or variables. Because nursing knowledge is rooted in nursing practice, and because an essential element of this knowledge is that it can be taught by nurses to future nurses, nursing knowledge in the current study was classified as two separate independent variables: education level and years of experience in nursing.

The specific participant demographics of age, gender, and the amount of time spent in direct patient care were selected as independent variables because basic characteristics of participants such as age and gender should be presented in a research report (Polit & Beck, 2017). The amount of time spent in direct patient care can be considered a basic characteristic of nurses and, thus, was also selected as an important participant demographic. Describing participant demographics provides researchers and readers with the necessary information they need to determine the generalizability of findings as well as the applicability of comparisons to future studies (Hammer, 2011). Personal experiences with significant others, family members, friends, and colleagues using and misusing opioids and the social attitudes of blame, danger, and choice were selected as independent variables based on literature supporting the importance of these variables in the stigmatization process.

### ***Purpose***

The purpose of this study is twofold. The first objective is to examine the relationships between nurses' knowledge (education level, experience level), selected demographics (age, gender, amount of time spent in patient care), social attitudes (blame, danger, choice), and personal experiences (with a family member, significant other, friend, or colleague with OUD) and nurses' perceptions of their abilities to provide equitable care to patients with and without

OD. The second objective of this research is to explore the predictability of nurses' perceptions of their abilities to provide equitable care to patients with and without OD by knowledge, demographics, personal experiences, and social attitudes.

### ***Theoretical Framework***

This research is grounded in the Health Stigma and Discrimination Framework (HSDf) which was developed by leaders in public health, social work, medicine, psychology, social policy, and epidemiology. The HSDf is a multidisciplinary theoretical framework intended to recognize and disrupt health-related stigma and to minimize the negative effects of health-related stigma and discrimination by providing a guide for research, social and healthcare policy, and intervention development and measurement (Stangl et al., 2019). The HSDf is unique in that it provides a comprehensive framework for application to all health conditions rather than to just one single stigmatized health condition. Because it has been useful in guiding nursing and health care practices concerning commonly stigmatized health conditions (e.g., COVID-19 infection, human papilloma virus (HPV), HIV/AIDS, and people living with HIV/AIDS (PLWHA)), and based on the inclusive format of the framework, the HSDf is well-suited to guide research on OD stigma and discrimination.

The HSDf has four levels. The first level constitutes the causes of health stigma, or the drivers and facilitators of stigma. The second level includes stigma 'marking', or the application of stigma because of a health condition or associated condition. The third level involves the manifestations of stigma- experienced stigma and stigma practices. And the fourth level comprises the outcomes of health-related stigma. Again, one goal of the HSDf is to recognize and disrupt the stigmatization process, and the first three levels of the HSDf are ideal for disrupting the stigmatization process (Stangl et al., 2019). Based on the integrative review

discussed above, and using the HSDF as a guide, nurses' lack of opioid knowledge is identified as the major facilitator of the OUD stigmatizing process. Disrupting this facilitator has the potential to prevent OUD stigma at the ground level, thus preventing the negative effects of OUD stigmatization proven to be so devastating. One aim of this research study is to explore the relationship between nursing knowledge and nurses' perceptions of their ability to provide equitable care. Determining whether these two variables are related will provide insight into the importance of nursing knowledge as a facilitator of OUD stigmatization, and it will also shed light on implications for future practice and research.

## **Methods**

### ***Design and Sample***

This is a secondary analysis of data from the 2022 Perception of Opioid Use Survey (POUS) using a cross-sectional design. The survey was administered to 123 nurses currently employed in emergency departments at several hospitals connected to a large health system in the South Atlantic United States. Inclusion criteria was adult nurses (licensed practical nurses, registered nurses, and nurse practitioners) aged 18 and older employed either full time, part time, or as needed in the emergency department with the ability to read and write English. Exclusion criteria included: non-nurses, nurses not employed either full time, part time, or as needed; minors; and anyone who cannot read and write English (Yearwood et al., 2024).

### ***Measures***

#### **Dependent Variable.**

The item operationalized as the dependent variable (DV) for this study was item 36 – “I am capable of providing the same care to my patients regardless of whether they misuse opioids” (*perceived equitable care*). This item is included in the domain self-efficacy, and a higher score

on the Likert scale (1-7) is interpreted as higher self-efficacy. Self-efficacy does not measure actual ability; rather, it measures the nurses' self-perceptions of ability. Due to the small sample size and low variability (all respondents either chose 5 (agree slightly), 6 (agree moderately), or 7 (agree strongly)), the dependent variable of *perceived equitable care* was regrouped from the 7-point Likert (disagree strongly-agree strongly) scale into a two-group categorical variable (slightly-moderately agree, strongly agree).

### **Independent Variables.**

The measures operationalized as independent variables in this data analysis were “years of experience as a nurse” (*nursing experience in years*; 0-5, 6-10, 11-15, 16-20, 21-25; 26+), “what is your highest level of education?” (*education level*; LPN (Licensed Practical Nurse), Associates Degree in Nursing (ADN), Bachelor’s Degree in Nursing (BSN), Masters Degree in Nursing (MSN), PhD/DNP (Doctor of Philosophy/Doctor of Nursing Practice), “what is your age?” (*age*; 18-29 years, 30-39 years, 40-49 years, 50-59 years, 60-69 years, 70 plus), “regardless of job title, do you spend at least 50% of your time in direct patient care?” (*amount of time in direct patient care*; yes/no), “what gender do you identify with?” (*gender*; non-binary/fluid, female, other, male, prefer not to disclose), “do you have experience with a family member or significant other misusing opioids?” (*personal experiences*; yes/no), and “do you have experience with a friend or colleague misusing opioids?” (*personal experiences*; yes/no). Due to a smaller sample size and low variability, *nursing experience in years* was collapsed from 6 groups into 4 groups (0-5 years, 6-10 years, 11-15 years, and 16+years), *age* was collapsed from 6 groups into 2 groups (under 40, 40 and over), and *gender* was collapsed from 4 groups into 2 (male, female).

Additional independent variables were three items covered under the scale “social attitudes” operationalized generally as nurses’ social attitudes: item 24- “People with opioid use disorder only have themselves to blame” (*blame*); item 25- “All people who misuse substances are dangerous” (*danger*); and item 17- “Opioid use disorder is a choice and persons who use opioids can decide to stop” (*choice*). For these three items, a higher score on the Likert scale (1-7) is interpreted as nurses having less social bias. To determine differences between nurses’ social attitudes (sub-variables *blame*, *danger*, and *choice*) and *perceived equitable care*, the Likert-scale response options (1-7, higher score = less social bias) were reverse coded (1 became 7, 2 became 6, 3 became 5, 5 became 3, 6 became 2, and 7 became 1) so that a lower score equaled less social bias for ease of interpretation.

### ***Ethics***

The University of Tennessee Knoxville Institutional Review Board (UTK IRB) granted full approval for this study in November 2023. Data from the 2022 POUS were de-identified and transferred via a secure file transfer service (University of Tennessee (UT) Vault). All data were stored on a UT-supported Google drive (One Drive) and access was only granted to the researchers and statistician working on this analysis. All data were destroyed at the conclusion of the analysis. The informed consent signed by participants of the 2022 POUS included consent for secondary analysis with other entities including universities.

### ***Data analyses***

Data were analyzed using SPSS v. 29. Descriptive statistics were calculated for all variables concerning the whole sample (N=123) when available including *education level*, *nursing experience in years*, *age*, *gender*, *time spent in direct patient care*, and *nurses’ personal experiences*. Missing values were handled with listwise deletion.

Chi-square tests were conducted to examine differences between *perceived equitable care* and *education level*, *nursing experience in years*, *age*, *gender*, *amount of time in direct patient care*, and *nurses' personal experiences*. To determine differences between nurses' social attitudes (sub-variables *blame*, *danger*, and *choice*) and *perceived equitable care*, *t*-tests were conducted. Binary logistic regression was used to determine whether nurses' knowledge, demographics, personal experiences, and/or social attitudes predicts nurses' perceptions of their abilities to provide equitable care to patients with and without OUD. The level of significance was set at  $p < 0.05$  for all statistical tests.

## Results

Participant characteristics and variable comparisons are presented in Table 5. Of the 123 respondents, 76 nurses (61.8%) strongly agreed they could provide equitable care to those with and without OUD, 30 nurses (2.4%) moderately agreed they could provide equitable care, and 15 nurses (12.2%) slightly agreed they could provide equitable care.

### Chi-square Comparisons.

There were significant differences in nurses' perceptions of their ability to provide equitable care by both *age* ( $p = 0.030$ ) and *nursing experience in years* ( $p = 0.046$ ). Eighty-one percent of nurses aged 40 and over strongly agreed they could provide equitable care to patients with and without OUD, while only 57% of nurses under the age of 40 strongly agreed they could provide equitable care. As age increased, nurses perceived a greater ability to provide equitable care. *Nursing experience in years* had similar results; over 92% of nurses with 16 or more years of experience strongly agreed they could provide equitable care.

There was no significant difference in nurses' perceptions of their abilities to provide equitable care to patients with and without OUD by education level ( $p = 0.649$ ) or personal

**Table 5***Descriptive statistics and comparisons for categorical variables*

| <b>Variables</b>                    | <b>N (%)</b> | <b>Slightly-moderately agree, N (%)</b> | <b>Strongly agree, N (%)</b> | <b>p-value</b> |
|-------------------------------------|--------------|-----------------------------------------|------------------------------|----------------|
| <b>Knowledge</b>                    |              |                                         |                              |                |
| Education level                     | 122          |                                         |                              | 0.649          |
| ADN                                 | 15 (12.3%)   | 4 (26.7%)                               | 11 (73.3%)                   |                |
| BSN                                 | 92 (75.4%)   | 35 (38.9%)                              | 55 (61.1%)                   |                |
| MSN                                 | 15 (12.3%)   | 6 (40.0%)                               | 9 (60.0%)                    |                |
| Nursing experience in years         | 122          |                                         |                              | 0.046          |
| 0-5                                 | 74 (60.2%)   | 29 (40.3%)                              | 43 (59.7%)                   |                |
| 6-10                                | 17 (13.8%)   | 9 (52.9%)                               | 8 (47.1%)                    |                |
| 11-15                               | 17 (13.8%)   | 5 (29.4%)                               | 12 (70.6%)                   |                |
| 16+                                 | 14 (11.4%)   | 1 (7.1%)                                | 13 (92.9%)                   |                |
| <b>Specific demographics</b>        |              |                                         |                              |                |
| Age                                 | 122          |                                         |                              | 0.030          |
| Under 40                            | 96 (78.7%)   | 40 (42.6%)                              | 54 (57.4%)                   |                |
| Age 40 and over                     | 26 (21.3%)   | 5 (19.2%)                               | 21 (80.8%)                   |                |
| Gender                              | 121          |                                         |                              | 0.759          |
| Male                                | 20 (16.5%)   | 8 (40.0%)                               | 12 (60.0%)                   |                |
| Female                              | 101 (83.5%)  | 36 (36.4%)                              | 63 (63.6%)                   |                |
| Time spent in direct patient care   | 123          |                                         |                              | --             |
| 50% or more                         | 119 (96.7%)  | --                                      | --                           |                |
| Less than 50%                       | 4 (3.3%)     | --                                      | --                           |                |
| <b>Nurses' personal experiences</b> |              |                                         |                              |                |
| Family member or SO                 | 123          |                                         |                              | 0.995          |
| Friend or colleague                 | 36 (29.3%)   | 13 (37.1%)                              | 22 (62.9%)                   |                |
|                                     | 37 (30.1%)   | 14 (38.9%)                              | 22 (61.1%)                   | 0.801          |

experiences (with family member or significant other,  $p = 0.995$ ; with a friend or colleague,  $p = 0.801$ ). There was no significant difference in the perceived ability to provide equitable care by gender ( $p = 0.759$ ); 64% of females and 60% of males strongly agreed they could provide equitable care to patients with and without OUD. Over 97% of the nurses surveyed spent 50% or more of their time in direct patient care; therefore, comparisons were not run.

### ***t*-test Comparisons.**

When determining the association between nurses' social attitudes (*blame*, *danger*, and *choice*) and nurses' perceptions of their ability to provide equitable care, there was a significant difference in two of the sub-variables (see Table 6). Nurses who strongly agreed they could provide equitable care to patients with and without OUD had statistically significant lower levels of social bias in regard to the sub-variables *blame* ( $p = 0.002$ ) and *danger* ( $p = 0.003$ ). There was no statistically significant difference between *perceived equitable care* and the social attitude *choice* ( $p = 0.457$ ). In terms of clinical significance, at least one respondent somewhat agreed (5= agree slightly, 6= agree moderately, 7= agree strongly) with each social attitude. In other words, while all respondents perceived they could provide some level of equitable care to patients with and without OUD, not all respondents refrained from the social biases of blame, danger, and choice.

### **Binary Logistic Regression.**

Binary logistic regression was conducted on all significantly related independent variables to determine the predictability of the dependent variable (see Table 7). The variables *age* and *nursing experience in years* were both significant and could be considered synonymous; therefore, *age* was used in the model because it was more statistically significant than *nursing*

**Table 6***Descriptive statistics and comparisons for continuous variables*

| <b>Variables</b>         | <b>Mean (SD)</b> | <b>Slightly-moderately agree; Mean (SD)</b> | <b>Strongly agree; Mean (SD)</b> | <b>Min.</b> | <b>Max</b> | <b>p-value</b> |
|--------------------------|------------------|---------------------------------------------|----------------------------------|-------------|------------|----------------|
| Nurses' social attitudes |                  |                                             |                                  |             |            |                |
| Blame                    | 2.15 (1.143)     | 2.53 (1.079)                                | 1.89 (1.078)                     | 1           | 6          | 0.002          |
| Danger                   | 2.12 (1.225)     | 2.53 (1.160)                                | 1.87 (1.193)                     | 1           | 5          | 0.003          |
| Choice                   | 2.96 (1.657)     | 3.09 (1.676)                                | 2.86 (1.655)                     | 1           | 7          | 0.457          |

**Table 7***Binary logistic regression model*

| <b>Predictors</b> | <b>B</b> | <b>S.E.</b> | <b>Wald</b> | <b>df</b> | <b>Sig.</b> | <b>Exp(B)</b> | <b>95% CI Lower</b> | <b>95% CI Upper</b> |
|-------------------|----------|-------------|-------------|-----------|-------------|---------------|---------------------|---------------------|
| Age               | 1.134    | 0.555       | 4.183       | 1         | 0.041       | 3.108         | 1.048               | 9.217               |
| Blame             | -0.410   | 0.219       | 3.505       | 1         | 0.061       | 0.664         | 0.432               | 1.019               |
| Danger            | -0.248   | 0.189       | 1.709       | 1         | 0.191       | 0.781         | 0.539               | 1.131               |

*experience in years* (0.030 vs. 0.046). The overall model was significant ( $-2LL = 142.7$ ,  $p = 0.001$ ). *Age* was a significant predictor of the nurses' confidence in their ability to provide equitable care ( $p = 0.041$ ). Nurses aged 40 and over were 3.1 (CI = 1.048 - 9.217) times more likely to strongly agree that they provide equitable care to those with and without OUD than nurses under 40. The social sub-variable *blame* approached significance ( $p = 0.061$ ) to predict *perceived equitable care*, and the social sub-variable *danger* was not a statistically significant ( $p = 0.191$ ) predictor of *perceived equitable care*.

## **Discussion**

### ***Age and experience***

This study showed that nurses' perceptions of their abilities to provide equitable care to patients with and without OUD was significantly associated with age, experience, blame, and danger. As nurses age, their confidence in their ability to provide equitable care increases. In fact, nurses aged 40 and over will strongly agree they can provide equitable care to patients with and without OUD over three times more than nurses under 40. Likewise, as nurses gain more years of nursing experience, their confidence in their ability to provide equitable care increases. Age and experience go hand in hand. If someone stays in the nursing field for any number of years, their nursing experience will increase as they age. The question then becomes – why do older and more experienced nurses perceive that they are able to provide equitable care at a higher level than younger, less-experienced nurses?

Further study is needed to investigate this phenomenon. Do older and more experienced nurses actually provide more equitable care? If older and more experienced nurses perceive they provide more equitable care than younger and less experienced nurses, but do not actually provide more equitable care, then why do older nurses feel this way? Because of the burgeoning

societal focus on stigma and discrimination, perhaps younger nurses who have been in nursing school more recently than their older counterparts critically analyze their abilities to provide equitable care more than older nurses, thus responding to surveys like the POUS from a more self-aware and self-critical mindset. Do younger nurses have more access, or more exposure, to current health and social issues as opposed to older nurses?

A literature reviewed conducted by Uthaman et al. (2016) found that older nurses reported having less access to continuing education activities compared to younger nurses (Wray et al., 2009), and one reason for this may be because employers want to retain younger nurses in the workforce (Armstrong-Stassen & Stassen, 2013). If older nurses are not benefiting from the same current education that younger nurses have, their perceptions of equitable care may not reflect their actual ability to provide equitable care. This finding needs more attention; continuing education and professional development opportunities should be provided to all nurses regardless of age or experience level.

An increase in age not only contributes to an increase in nursing experience, but it also presumably contributes to an increase in life experience. Perhaps more life experiences allow nurses to practice with more self-awareness and less biases and assumptions. Alternatively, the opposite could be true. Life experiences could generate more biases and assumptions and cause older nurses to be less aware of providing inequitable care. These thoughts tangentially align with Mahmoud et al.'s (2021) findings which detailed the significant relationship between nurse motivation levels and their relationship with personal experiences. Mahmoud et al. (2021) found if a nurse had a family member with a current or historical substance use issue, that nurse would be more motivated to provide high quality care to patients with a substance use issue. While the relationship between nurses' personal experiences and their perceived abilities to provide

equitable care did not have a significant relationship in the current study, empirical evidence suggests that experiences, perhaps gained solely through living and aging, or perhaps gained through the aforementioned factors plus experience with a family member or friends, may be contributors to equitable care.

Grounding the current study in the Health Stigma and Discrimination Framework (HSDF) provided an outline of the stigmatization process including its potential harmful effects. A lack of nursing knowledge (education and experience) was identified as the major facilitator of OUD stigmatization in the 2022 integrative review that spurred this study, and it was proposed that disruption of this facilitator could ultimately halt the OUD stigmatization process. Education level was not significantly related to the perceived ability to provide equitable care to patients with and without OUD in this study; however, a relationship still could exist. The concept of nursing knowledge should be expanded to include education level, years of experience in nursing, self-efficacy, self-awareness, and supplemental education through continuing education, seminars, workshops, and conferences. Future study needs to focus on these variables to identify whether education level may be significantly related to equitable care in larger populations or in different areas. Age certainly is not something that can be manipulated, added, or removed to increase nurses' abilities to provide equitable care. Years in nursing experience cannot be altered either, but the quality of experience could be modified to include current important healthcare and social knowledge. Targeted opioid education in certain intervals during a nursing career, along with more nursing experience coupled with mentorship from other nurses, could increase nurses' confidence in their ability to provide equitable care. Future research should explore targeted teaching interventions and the impact these interventions have on the provision equitable care.

### *Social attitudes*

While nurses' social attitudes of *blame* and *danger* could not significantly predict nurses' perceptions of their abilities to provide equitable care, they were significantly related to *perceived equitable care*. Nurses who strongly agreed they could provide equitable care to those with and without OUD agreed with the statements "people with opioid use disorder only have themselves to blame" (*blame*) and "all people who misuse substances are dangerous" (*danger*) less strongly than those who slightly or moderately agreed they could provide equitable care. In other words, nurses perceived they had less ability to provide equitable care when they placed blame on patients with OUD and considered them to be potentially dangerous.

Interestingly, while all respondents perceived they could provide equitable care by selecting either 5 (agree slightly), 6 (agree moderately), or 7 (agree strongly) on the survey item of *perceived equitable care*, not all respondents refrained from harboring the social attitudes of *blame*, *danger*, and *choice*. Therefore, while all respondents agreed to some degree they could provide equitable care, some respondents still placed blame on patients with OUD, thought they were dangerous, and thought OUD is a choice and persons using opioids can decide when to stop. This finding is clinically significant because it shows one instance of disparity between nurses' perceptions of their abilities to provide equitable care and their social attitudes.

Nurses' social attitudes manifest in the care they provide. Current literature shows that patients feel judged and blamed for their OUD (Blair et al., 2021; Simon et al., 2020) and nurses have placed shame and guilt on patients with OUD (Reese et al., 2021) and even their families (Sapp & Hooten, 2019). Some people with OUD are even stereotyped as being dangerous (Yang et al., 2019). Supplemental education through continuing education modules directed towards social attitudes, the negative effects that these social attitudes can have, and the mitigation of

biases associated with these attitudes should be piloted in health institutions to all nurses, not just during the orientation process which is likely to involve younger nurses. Additionally, mentoring programs among nurses and those experiencing or recovering from an OUD focused on social attitudes may help all nurses, older and younger, more and less experienced, understand the benefits of equitable care and the harmful effects of stigmatization.

### ***Key Implications***

The objective of studying nurses' perceptions of their ability to provide equitable care to patients with and without OUD is to better understand their beliefs about the care they provide. As it is mentioned throughout this paper, there is no objective measurement of equitable care which is why most accounts of the quality of care are self-reported and are, thus, inherently perception. If nurses could perceive the care they provide accurately and as close to reality as possible, the gaps in equitable care could be more accurately described. To move closer toward meeting this objective, nurses need to know what equitable care is and what it looks like in the context of caring for patients with and without OUD and all stigmatized health conditions. Nurses need to appreciate the negative impacts of OUD stigmatization on individuals, families, and communities, and understand the upstream manifestations of practiced and experienced stigma. With this greater knowledge, nurses could more accurately perceive the quality of care they provide which would increase self-awareness and self-efficacy.

The findings of this study reveal that nursing knowledge is not simply comprised of education level and nursing experience in year. Nursing knowledge incorporates many factors including life experiences, personal experiences, teaching and learning after nursing school, experiential learning, and social and political views. As stated previously, the concept of nursing knowledge should be expanded to include the above factors along with education level, years of

experience in nursing, self-efficacy, self-awareness, and supplemental education through continuing education, seminars, workshops, and conferences. In the integrative review prompting this study, the concept of a lack of nursing knowledge was identified as the key facilitator of OUD stigmatization according to the HSDF. The findings of this study show that a lack of nursing knowledge as previously defined (education level and years of nursing experience) is not a facilitator of OUD stigmatization, but the revised and more comprehensive description of nursing knowledge could, in fact, be the key facilitator of the stigmatization process. Further study needs to explore this newer classification of nursing knowledge with all it comprises.

### ***Additional Implications***

The current state of the science of OUD stigmatization and perceived equitable nursing care, coupled with these research findings, conveys implications for both clinical and scientific nursing. More research needs to be done with the POUS. The survey should be administered to diverse populations of nurses around the country and even globally to understand the benchmark from which nurses perceive equal and unequal care and stigmatizing behaviors. Nurses should be made aware of their own personal biases and social attitudes through targeted education, self-reflection, and introspection, and these interventions should be encouraged by health care systems with the goals to increase nurses' self-awareness and decrease the stigmatization of patients with OUD and any health condition. Future research needs to focus on measuring nurses' perceptions of their abilities to provide equitable care to patients with all stigmatized health conditions, not just OUD.

An objective measure is needed in addition to the subjective findings provided in this study. Correlating patient care outcomes with nurses' perceptions of their abilities to provide equitable care could provide valuable and more objective insight into this issue. Another measure

that could prove valuable with further investigation is surveying both nurses and patients about their perceptions of the provision of equitable care. Discriminative nursing care (DNC) is double-sided and includes the perceptions of the care provided to patients with and without OUD from the nurses' and patients' perspectives (Bernier & Barroso, in 2024). Administering a survey to nurses and the patients for whom they care could shed more light on DNC, nurses' perceptions of the care they provide, and patients' perceptions of the care they receive.

The opioid epidemic has been exceptionally devastating to people experiencing OUD, their families, their communities, the health care system, and to greater society for the past several decades. OUD stigmatization is one important piece contributing to the opioid epidemic and its effects are too great to ignore. It is incumbent upon all those working in the health and social disciplines to address the areas of the opioid epidemic pertaining to their work and expertise. Health care providers must understand the stigmatization process related to health conditions. Subsequently, they must appreciate the detrimental effects stigma can have on their patients and communities. Collaboratively addressing OUD stigma, and all health-related stigmas, in a way that informs clinical practice and health care delivery should be a priority to improve health outcomes of patients experiencing stigmatized health conditions.

It is incumbent upon professionals working with and treating people and families affected by OUD to function according to the most current best practices available. To achieve this, providers and clinicians could seek innovative, multidisciplinary frameworks like the Health Stigma and Discrimination Framework (Stangl et al., 2019) to identify areas where change is necessary and to determine how change might affect patient outcomes. Likewise, health facility administrators should solicit input from these providers and clinicians to work toward developing

a stigma-free healthcare environment through training and institutional policy updates and changes (Stangl et al., 2019).

Equitable care does not originate with a certain individual. Providing and facilitating equitable care is the responsibility of every individual working in health and social disciplines. Thus, professionals in these disciplines need to share their knowledge and experiences for the benefit of their peers, the system as a whole, and, most importantly, the patients and clients for whom they care. Likewise, health and social professionals should seek out opportunities to learn from their peers in other disciplines to grow and enhance the practices in their own discipline. Interdisciplinary collaboration between key participants in professional disciplines is essential to ameliorate stigma and discrimination towards those experiencing OUD.

### **Limitations**

The major limitation of this study was the subjective nature of the dependent variable. *Equitable care* was self-reported and is, therefore, not measurable on any objective scale. Even if participants responded to this item with their honest opinion of the care they provide, their opinion is subjective and may not match the opinion of patients or other nurses. Similarly, there was a potential for response bias due to the sensitive nature of the dependent variable and social attitudes sub-variables (Burton et al., 2021). Participants may have selected responses they assumed to be socially or morally acceptable rather than the response best reflecting their perceived ability to provide equitable care.

While not objective measures, self-assessment surveys (like assessing perceived ability to provide equitable care) are reliable (Ross, 2019) and are important tools in advancing nursing science (O'Connor, 2021). The POUS instrument was deemed valid and reliable through psychometric testing (Yearwood, 2024). Several items analyzed in this study were selected from

two scales of the POUS: self-efficacy (dependent variable) and social attitudes (blame, danger, and choice). These two scales had acceptable internal consistency (Cronbach's  $\alpha = 0.796$  for self-efficacy, and Cronbach's  $\alpha = 0.744$  for social attitudes); however, the overall internal consistency of the survey was poor with Cronbach's  $\alpha = 0.550$  (Yearwood, 2024). The measurement tool should be reassessed and modified to improve overall internal consistency.

Using rigorous, high-quality surveys strengthens evidence-based practice and has a positive influence on health care delivery (O'Connor, 2021). One strategy to address the stated limitation is to include a second evaluator for self-assessment items, perhaps a manager or colleague. Self-assessment measurements are typically completed by the participant and another person to compare results. If the results of the measurement are similar, the self-assessment result is considered to be more accurate; when discrepancy results, the result is considered to be less accurate (Violanti & Kelly, 2023).

A related limitation was the narrow operationalization of the concept of nursing knowledge. Education level and years of nursing experience are components of nursing knowledge, but they do not define nursing knowledge. Therefore, nursing knowledge was not assessed in this study. Additionally, the data analyzed in this study were the pre-teaching intervention data from a study conducted in 2022. The implementation of the POUS in the 2022 study by Yearwood et al. was intended to assess nurses' knowledge, attitudes, and practices towards patients using opioids before and after one of two educational sessions focusing on stigma and biases towards patients with OUD (Yearwood, 2024). Therefore, the results of this study are limited to the initial administration of the survey before any teaching intervention.

A potential limitation associated with using the POUS survey tool in this study was the participant population of emergency room (ER) nurses. The 2022 POUS was administered to ER

nurses at several hospitals in a major health system. Some may have the opinion that ER nurses do not care for hospitalized patients; they care for emergency room patients. ERs are an integral part of the hospital, and many patients first seen in the ER will be admitted to hospital care. Additionally, nurses working in the ER do not have nursing experience limited to the ER. Many nurses working in the ER have worked, or currently work, in other hospital areas. The topic of this paper is the stigmatization of hospitalized patients in general, or patients receiving care in the hospital including specialty areas, not solely inpatients receiving inpatient care.

The current study analyzed data collected from a previous study (secondary data analysis). A limitation related to secondary data analysis is the unplanned nature of post-hoc analysis, and analyzing data from a previously conducted study could lead to coincidental findings rather than statistical relationships (Ross & Zaidi, 2019). The small sample size of this study limited variability of comparisons. Additional studies with more participants should be conducted using the POUS for greater variability and to compare to the current findings. Future studies using the POUS should be conducted at different health systems and in different parts of the country and world for comparison and to increase the generalizability of findings.

A potential limitation of grounding this study in the HSDF is the fact that the HSDF is not specifically a nursing theory or framework; it is intended for use across all healthcare disciplines worldwide (Stangl et al., 2019). While grounding nursing practice and research in nursing theory has been shown to improve nursing care (Younal & Quennell, 2019), enhance strategies to support nursing practice, and facilitate nursing knowledge growth (Matney et al., 2015), it is not required for a nursing study to have roots in a nursing theory. The importance lies in the chosen theory or framework's core concepts. To be useful in a nursing study, the theory or framework should include four concepts central to nursing: human beings, health, nursing, and

environment (Fawcett & DeSanto-Madeya, 2013) The HSDF clearly involves human beings, health and environment, and the concept of nursing is open to interpretation by those developing and using the theory or model (Polit & Beck, 2017). Nurses are a central concept in this study and in the current operationalization of the HSDF; therefore, this potential limitation is mitigated.

## **Conclusion**

The current study provided an overview of discriminative nursing care (DNC) towards patients with OUD and the detrimental effects of the stigmatization of health conditions. Guided by the Health Stigma and Discrimination Framework (HSDF), the relationships between nurses' OUD knowledge, selected demographics, social attitudes, and personal experiences and their perceptions about their ability to provide equitable care to patients with and without OUD were explored. Data from the 2022 POUS were analyzed through various methods to reveal age, years of nursing experience, blame, and danger were all significantly related to nurses' perceptions of their ability to provide equitable care. Finally, the importance of these findings was discussed along with implications for future nursing research and practice.

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## **CHAPTER V**

### **DISCUSSION AND CONCLUSION**

Discriminative nursing care (DNC) towards those with opioid use disorder (OUD) is an important issue in today's health care environment. DNC contributes to negative outcomes for individuals and communities (Bernier & Barroso, 2024; Horner et al., 2019; Jaiteh et al., 2019; El Rasheed et al., 2016). People with OUD who seek hospital treatment experience delays in care, poor communication with health care providers (Jaiteh et al., 2019), and inadequate pain control (Horner et al., 2019). Experiencing stigma can also cause depression, anxiety, anger, social isolation, social rejection, and self-isolation (Earnshaw, 2021). People with OUD are stereotyped as being dangerous and unpredictable, and they are even blamed for their illness in some cases (Yang et al., 2018). Being stigmatized because of a health condition like OUD has been linked to patients leaving the hospital early (against medical advice), which increases the risk of experiencing negative health outcomes (Simon et al., 2020). When these negative health outcomes persist and worsen, increased morbidity and mortality can result (Earnshaw, 2021; Horner et al., 2019; Jaiteh et al., 2019).

Community outcomes of OUD stigmatization include unemployment and housing disruption which can perpetuate a dangerous cycle. Employment opportunities may be blocked or terminated by employers when an employee has a positive drug test or even when an employee's history of OUD or engagement in recovery is exposed (Earnshaw, 2021; Richardson & Epp, 2016). A lack of employment makes it more difficult for someone to secure housing. Additionally, people with past or present drug use, including opioid use, may be turned away by housing agencies (Lopez & Reid, 2017), augmenting the difficulty to secure housing. As a key social determinant of health, secure housing is vital for someone trying to recover from OUD. OUD treatment has been found to be less effective when someone without housing is discharged from the hospital after care, and housing disruption has been linked to negative health and social

outcomes such as malnutrition, exposure to infectious diseases, violence, developing or worsening substance use disorders, and even death (National Health Care for the Homeless Council (NHCHC, 2019). Consequently, OUD stigmatization can cause barriers to employment and housing disruptions, and housing disruptions can, in turn, cause worsening OUD along with other negative and social outcomes. This cycle can be detrimental and nearly impossible to overcome for individuals with current or historical OUD.

Because nurses typically spend the most time with patients receiving hospital care (Shreffler et al., 2021), it is vital to learn more about the OUD stigmatization process and nurses' perceptions of their ability to provide equitable care to patients with and without OUD. In this research study, data from the 2022 Perception of Opioid Use Survey (POUS) were analyzed to determine the relationships between nurses' perceptions of their ability to provide equitable care and nursing knowledge, demographics, personal experiences, and social attitudes. Findings from these analyses are important to the discipline of nursing in practice, research, policy, and continuing education.

## **Discussion**

Several variables examined during secondary data analysis were found to be significantly related to nurses' perceptions of their abilities to provide equitable care to patients with and without OUD (perceived equitable care), and they included age and experience in nursing, as well as nurses' social attitudes of blame (those with OUD only have themselves to blame) and danger (all those who misuse substances are dangerous). Nurses' education level was not found to be significantly related to perceived equitable care; however, education level is coupled with experience in nursing to construct the concept of nursing knowledge in this study. The relationship between nursing knowledge and equitable care is notable and warrants further

discussion. The variables gender, amount of time spent in direct patient care, nurses' personal experiences, and the social attitude of choice (i.e., OUD is a choice and persons using and misusing opioids can choose when to stop) were not significantly related to perceived equitable care.

### ***Age and experience***

Age and years of nursing experience were significantly related to nurses' perceptions of their abilities to provide equitable care. As nurses age and gain years of nursing experience, their confidence in their ability to provide equitable care to patients with and without OUD increases. In addition to being significantly related to perceived equitable care, age was the only independent variable found to predict perceived equitable care. Nurses aged 40 and over were over three times more likely to believe they could provide equitable care to those with and without OUD than nurses under the age of 40. Age and experience function in concert; nurses will gain years of experience as they age. As nurses age, they not only gain years of nursing experience, but they also gain years of life experiences. Because the perceived ability to provide equitable care is a subjective measure of self-assessment, questions related to perception matching reality arise. Do older and more experienced nurses actually provide more equitable care than younger, less experienced nurses? Or do they simply think they provide more equitable care when in reality, they provide the same or less equitable care than their younger, less experienced colleagues? A key recommendation from this study is to further explore nurses' perceptions of their abilities to provide equitable care and identify factors contributing to these perceptions.

A proposition raised in chapter 4 of this dissertation suggested that perhaps younger nurses are more self-aware and self-critical of the care they provide due to the health and social

climate in which they began practicing as opposed to the health and social climate existing when nurses over 40 began practicing. The opioid epidemic began in the 1990s with an increase in prescribing of natural and semi-synthetic opioids (Centers for Disease Control and Prevention [CDC], 2023). In the mid 1990s, pain was coined “the fifth vital sign” in an effort to improve pain management and the care of those with acute and chronic pain (Scher et al., 2018). As a focus on pain grew, and more importantly, on stopping pain altogether, the market for prescription opioids flourished. The cost and demand for these prescription medications increased, and by 2010, people needing pain medication and those dependent on opioids turned to heroin because its effects were similar to that of opioids and it was much less expensive. After several years, the prevalence of synthetic opioids like fentanyl increased greatly and overdose deaths continue to rise (CDC, 2023). The opioid epidemic was not declared a nationwide public health emergency in the United States until 2017 (American Psychiatric Association [APA], 2022).

Nurses who have been practicing since the 1990s and 2000s experienced the opioid epidemic as it began and grew. Diagnosis for OUD as a mental health disease was not founded until the 2000s, and as the use of opioids grew, nurses cared for more patients using opioids than ever before. The perspectives from which nurses provide care impact the care provided (Shreffler et al., 2021). How different are the perspectives of nurses over 40 than the perspectives of nurses over 40? How did nursing in the early years of the opioid epidemic shape the perspectives and perceptions of those nurses? Comparing older nurses’ perspectives on the opioid epidemic and their perceptions of their abilities to provide equitable care with younger nurses’ perceptions could illuminate the differences between these perspectives if any differences exist.

Because the opioid epidemic is prominent in today's social, political, and healthcare landscapes, opioid education in nursing schools and hospital education modules is taught through the lens of OUD as a diagnosable disease. Younger and less-experienced nurses perhaps have the benefit of learning about OUD and other substance use disorders from these viewpoints rather than the viewpoints of educators and colleagues before OUD was a recognized mental health illness. Does the educational preparation and the perspectives from which they were taught to younger, less-experienced nurses impact their perceptions of their abilities to provide equitable care, and how do these perspectives and, thus, perceptions, differ in nurses aged 40 and older with more nursing experience?

In the secondary analysis conducted on data from the 2022 POUS, nurses' personal experiences (experience with a significant other, loved one, friend, or colleague using or misusing opioids) were not significantly related to nurses' perceptions of their abilities to provide equitable care to patients with and without OUD. This finding indirectly contradicts Mahmoud et al.'s (2021) findings explaining that when a nurse had a relationship with a family member with a substance use issue like OUD, the nurse's motivation to provide quality care to patients with substance use issues increased. A proposed explanation of this finding is perhaps life experiences other than personal experiences contribute to less social bias and the ability to provide equitable care. More research is needed to determine the effects of social contact and other social experiences on nurses' perceptions of their abilities to provide equitable care to those with and without OUD. Additionally, the POUS should be administered to larger populations of nurses in multiple areas to confirm or disprove the insignificant relationship between nurses' personal experiences and their ability to provide equitable care found in this study.

### *Nursing knowledge*

In a 2022 integrative review seeking to identify the underlying themes of DNC towards people with OUD in the hospital setting, a lack of nursing knowledge related to opioids and OUD was recognized as the major facilitator of OUD stigmatization. According to the Health Stigma and Discrimination Framework (HSDF), disrupting drivers and/or facilitators of stigma could ultimately halt the stigmatization process of any health condition (Stangl et al., 2019). Therefore, disrupting the facilitator *lack of nursing knowledge* could stop the OUD stigmatization process before stigma practices and experiences can manifest. Based on the limited definition of nursing knowledge in this study, increasing nurses' knowledge level involves increasing their education level and years of experience. Years of experience is not something that can be manipulated. Education level can change, and future study needs to assess the relationship between education level and nurses' perceptions of their abilities to provide equitable care to larger populations than the one available for the current study.

As identified in chapter 4 of this dissertation, the concept of nursing knowledge needs to be expanded well beyond the limiting components of education level and years of nursing experience. While the concept of nursing knowledge is abstract and multidimensional which makes a finite definition impossible to suggest (Hall, 2005), review of literature and findings from the current study provide recommendations for criteria to include in the concept of nursing knowledge. The components of nursing knowledge should include education level, years of nursing experience, self-efficacy, self-awareness, supplemental education gained formally (through schooling, continuing education, workshops, and conferences) and informally (through experiential learning and social interactions), social views, and political views. Nursing knowledge is a central theme in findings from previous studies establishing that nurses and

patients alike feel that some nurses lack the necessary knowledge to adequately care for patients with substance use issues like OUD (El Rasheed et al., 2016; Hawk et al., 2022). Applying an expanded description of nursing knowledge to this issue opens myriad avenues for future research.

### ***Social Attitudes***

Nurses' social attitudes of blame ("people with opioid use disorder only have themselves to blame") and danger ("all people who misuse substances are dangerous") were significantly related to nurses' perceptions of their abilities to provide equitable care to those with and without OUD. The relationships were inverse; the less blame and danger a nurse attributed to a person with OUD, the more confident they were in their abilities to provide equitable care. This finding was logical and clinically significant. Nurses have described placing shame and guilt on people with OUD and their families (Reese et al., 2021; Sapp & Hooten, 2019). Correspondingly, patients with OUD have described feeling judged, blamed, and stereotyped as being dangerous for their health condition (Blair et al., 2021; Simon et al., 2020; Yang et al., 2018). The findings of this study showed that nurses who agreed with these negative social attitudes were less confident in their ability to provide equitable care.

An interesting and clinically significant finding in the current study was that while all nurses either slightly, moderately, or strongly agreed they could provide equitable care, some participants acknowledged blaming patients for their OUD, thinking OUD was a choice, and perceiving that those misusing opioids are dangerous. This is significant because it highlights the disparity between nurses' perceptions of their abilities to provide equitable care and their social attitudes. More research is needed on nurses' social attitudes surrounding OUD and other

stigmatized health conditions to understand the basis for these attitudes and to approach them in an evidence-based manner.

### **Contributions to nursing science**

This dissertation project achieved several contributions to nursing science, including successful operationalization of the HSDF as a middle-range nursing theory, analytical findings derived from a newer measurement tool, identification of significantly related variables to nurses' perceptions of their abilities to provide equitable care, and currently insignificant variable relationships that warrant future exploration and research. The HSDF is not a nursing theory; is a healthcare framework intended for use across disciplines and all health conditions to organize concepts, measures, and procedures. One goal of the HSDF is to provide a framework allowing for comparative research across all illnesses and fields to identify effective interventions for the general population (Stangl et al., 2019). The current study was grounded in the HSDF as a middle range theory because of its practice-level implications for nurses and members of the interdisciplinary health care team. OUD was the health condition studied in this research, but the HSDF is not limited to one diagnosis or population. Therefore, it can be used as a middle range theory to guide research focused on clinically significant interventions.

This research analyzed data from the Perception of Opioid Use Survey which was developed and piloted in 2020 (Burton et al., 2021) and revised for the 2022 study (Yearwood, 2024) which provided the data analyzed in this study. High-quality surveys are important tools in enhancing nursing science and positively impacting patient care and the health care delivery system (O'Connor, 2021), and working with newer surveys like the POUS is necessary to advance the use of the tool, to increase its recognition among nursing researchers, and to evaluate it for potential modifications. Through secondary analysis of data from the 2022 POUS,

age, experience in nursing, blame, and danger were found to have significant relationships with nurses' perceptions of their abilities to provide equitable care to people with and without OUD. These findings contribute to the body of nursing science. They, along with statistically insignificant but clinically significant findings, illuminate proposed directions and implications for future research. Finally, this research contributes to the body of knowledge surrounding the concept of nursing knowledge. It provides rationale for continuing to explore and define this abstract concept and to continue to develop measures to analyze and improve it.

### **Implications**

To achieve system-wide changes in the health care provided to those with substance use issues like OUD, practitioners, researchers, administrators, educators, policymakers, and all those involved with health and community resources must recognize the existence of and wide-reaching impacts of stigmatization. OUD stigmatization can have detrimental, even deadly, effects (Earnshaw, 2021), and it is the responsibility of all involved in the provision of health care to work towards disruption the stigmatization process. The current study sheds light on implications for future research, nursing practice, education, and policy.

### ***Direction for future research***

More research on the general topic of OUD stigmatization is needed to stop the stigmatization process and, thus, stop the negative effects of OUD stigmatization to individuals, families, communities, and society. Specifically, future research should focus on the drivers and facilitators of OUD stigmatization and strategies to combat these harmful causes of stigma manifestations. The HSDF is a valuable guide for transcultural scholars and practitioners because it allows for concise, specific assessments of stigma that can be operationalized across disciplines and health conditions. A central principle of the HSDF is its applicability to all health

conditions; therefore, research needs to expand beyond traditionally stigmatized health conditions. Conceptualizing health-related stigmas with the same terminology and stigmatization process would allow researchers an accessible link and comparison tool between health conditions and provide a more comprehensive path forward for future research (Stangl et al., 2019).

A key recommendation for future research is to expand the understanding of nurses' perceptions of their abilities to provide equitable care to patients with and without OUD. The current study explained that, while there is no objective measurement of equitable care, self-assessment of the ability to provide equitable care is a reliable and important measure even with the associated limitations. Nurses have perceptions about the care they can provide, and if nurses could perceive the care they provide as accurately to reality as possible, the gaps in equitable care could be more precisely described. A qualitative research study exploring the experiences of nurses caring for patients with opioid use disorder could shed light on the perspectives from which nurses provide care as well as the aspects contributing to their perceptions of the care they provide. This study should consider how a nurse's age and years in nursing impact their experiences and can lead to even more research on the topic. What is the lived experience of nurses' caring for patients with opioid use disorder in the height of the opioid epidemic? How do the experiences of older and younger nurses differ? This research would consider the differences between older nurses who "grew up" as the opioid epidemic unfolded and younger nurses who benefit from the knowledge gained through study and trial and error during the crisis. Accounts of the education specific to substance use and social stigma during different times in nursing history would be illuminated.

Case study research would be an appropriate next step following the current study to explore the experiences of older and younger nurses in the current healthcare climate. Because case study research is appropriate for groups of people, as in a group of nurses or a group of nurses and patients together, it would be a valuable research method to address the experiences of nurses and patients at different points in time over the last 30 years. Case studies involve the collection of different types of information including documents, records, interviews, and observations (Creswell & Poth, 2018). The possibilities for case studies related to this topic are numerous and exciting. Additionally, patients with current or historical OUD who have received hospital care should be interviewed to gain knowledge about how, if at all, nursing care and the delivery of equitable care has evolved over the last 30 years from their perspectives.

Another recommendation for future research is implementing the POUS to larger and more diverse populations. Findings of these studies should be compared to each other and to the current study to better understand the perspectives from which nurses are providing equitable and inequitable care. Subsequently, relationships between variables analyzed in this study, as well as relationships between variables not yet studied, need to be explored in future research.

A critical role of researchers in health condition stigmatization science is the dissemination of their work for the benefit of other researchers, clinicians, and program implementers in need of the most current, evidence-based practices. But this should not be done in silos. Rather, the inherently interdisciplinary nature of OUD stigma and discrimination compels the blending of research among the different but related disciplines.

## ***Education***

Insufficient nursing knowledge is a known contributor to stigmatizing patients with OUD. Nursing education level did not have a significant relationship with nurses' perceptions of their abilities to provide equitable care, but nursing education does not solely comprise nursing knowledge. Nursing knowledge consists of formal education, continuing education, life experiences, personal experiences, and social views, political views, self-efficacy, and self-awareness. With the expanded understanding of nursing knowledge set forth in current literature and in this paper, the main implication of the current study to nursing education is the need for direct, subject matter education on OUD as a disease, its pathophysiology including its mental, physical, and social manifestations, as well as the social climate in which OUD occurs. Stigma should be a focus of initial and continuing education; particularly what stigma looks like in the context of equitable care and the negative outcomes that can arise from OUD stigma. Hospitals, health care offices, substance use clinics, and recovery clinics should provide education to staff members and patients alike. Discussing and combating stigma should be approached with transparency and openness with the common goal of improving patient care and patient outcomes. Likewise, professionals working with and treating people and families affected by OUD should function according to the most current best practices available.

## ***Nursing practice***

Providers and clinicians should seek innovative, multidisciplinary frameworks like the Health Stigma and Discrimination Framework to use to identify areas where change is necessary and to determine how change might affect patient outcomes. Likewise, health facility administrators should solicit input from these providers and clinicians to work toward developing a stigma-free healthcare environment through training and institutional policy updates and

changes (Stangl et al., 2019). Equitable care does not originate with a certain individual, a certain doctor, or a certain nurse. Providing and facilitating equitable care is the responsibility of every individual working in health and social disciplines. Thus, professionals in these disciplines should share their knowledge and experiences for the benefit of their peers, the health care system, and, most importantly, the patients and clients for whom they care. Similarly, health and social professionals should seek out opportunities to learn from their peers in other disciplines to grow and enhance the practices in their own discipline. Interdisciplinary collaboration between key participants in professional disciplines is essential to ameliorate stigma and discrimination towards those experiencing OUD.

Because providing effective care to people with substance use disorders like OUD is complex and multidimensional, a team-based approach with collaboration across multiple health care fields is recommended to produce the best possible outcomes (Monteiro et al., 2017). Nurses, physicians, respiratory therapists, social workers, case management, and all those involved in the care of someone with OUD need to know the full picture of the patient's health and plan of care to provide the best, evidence-based treatment. Interdisciplinary collaboration has the potential to reduce OUD stigma and discrimination because it allows providers to better address the multitude of factors influencing patient, family, and community health (Sullivan et al., 2015).

### ***Policy***

Policymakers play an important role in improving patient outcomes. They can facilitate change on a larger scale to reduce opioid stigma and its negative effects on individuals and communities. Health care professionals and community members facilitate change through individual acts, services, and improving stigma education for themselves and others. Researchers

provide empirical evidence and recommendations for health professionals, community members, and policymakers to use. Policymakers have the unique power to enact rules and regulations and allocate funding which can impact vast numbers of people experiencing OUD and their families, as well as the health care delivery system, community members, and researchers alike.

It is the role of the policymaker to remain open to advice and recommendations from stigma researchers, health care institutions, and community advocates, to listen to the lived experiences of those directly affected with OUD, and to be open to the suggestions of those on the front lines working with the OUD-affected community to facilitate change and improve the health and lives of those experiencing OUD (Stangl et al., 2019). For example, as discussed previously, certain housing and employment policies have adverse impacts on those with current or historical OUD which perpetuates the disadvantages faced by those with OUD resulting in negative health outcomes and overall negative societal impacts (Earnshaw, 2021). The Americans with Disabilities Act (ADA) provides protections for people with OUD because OUD is recognized as a disability (ADA.gov, 2024). Impeding the employment opportunities for someone with OUD who is not using illegal drugs is a violation of the ADA, and instances of this need to be brought to the attention of policymakers.

The cyclical effect of OUD stigmatization leading to barriers to employment can also lead to housing disruption. Being unhoused can facilitate the development of comorbidities and lead to additional substance misuse, which leads to more hospitalizations. Recurrent hospitalization drains health care resources and can intensify the stigma toward this patient population when front-line health care providers treat the same patients for the same conditions without any positive conclusion. It is the responsibility of everyone invested in the health of

individuals and the public- nurses, health care professionals, community members, researchers, and policymakers- to work together to mitigate opioid stigma and discrimination.

## **Conclusion**

The opioid epidemic has negatively impacted the health and well-being of millions of people in the United States and worldwide, and stigma and discrimination towards those with OUD result in worse health and social outcomes for individuals, families, communities, and society. Nurses are on the front line of caring for this patient population. Working with other providers, community partners, researchers, administrators, and policymakers, those assuming care for this disadvantaged group are in a unique position to recognize and stop or mitigate the stigmatization process related to opioid use and misuse. Grounded in the Health Stigma and Discrimination Framework, the current research explored the relationships between nurses' knowledge, a major facilitator of health-related stigma, and nurses' perceptions of their abilities to provide equitable care to patients with and without OUD. Relationships between nurses' demographics, personal experiences, and social attitudes and nurses' perceived abilities to provide equitable care were investigated. The importance of and applicability to current nursing practice, education, policy, and research were identified, and key recommendations for future study were emphasized. Publication of this research will disseminate findings and important proposals for future research to the nursing community, as well as to the broader health care community, to bring heightened awareness to the importance of OUD stigma research.

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## **VITA**

Jeanne Adam Bernier was born in Vienna, Virginia to Warren and Claudia Adam. She is one of eight children who now live around the country with their families. She and her family live in Knoxville, Tennessee. Jeanne earned her BSN from the University of Alabama Capstone College of Nursing in 2006 and her MS in Nursing Education from the University of Mississippi Medical Center in 2014. She worked as a staff nurse and charge nurse at several hospitals in the southeast from 2006-2017. Her passion is medical-surgical and gerontological nursing. Jeanne began teaching undergraduate nursing courses at Mississippi College in 2014, and she is currently a nursing instructor and director of the master's program.

As a PhD candidate at the University of Tennessee Knoxville, Jeanne's area of study involves the stigma and discrimination of those with opioid use disorder. Her goals after completing her PhD requirements are to remain in academia and teach undergraduate and graduate level nursing students. She hopes to continue the research she began at UTK through new projects as well as presenting her work at state and national conferences.