


ORIGINAL RESEARCH

Emergency Medical Services

Compassion, stigma, and professionalism among emergency personnel responding to the opioid crisis: An exploratory study in New Hampshire, USA

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Abstract

Objective: Drug overdoses are the leading cause of death in the United States for those under 50 years of age, and New Hampshire has been disproportionately affected, resulting in increased encounters with the emergency response system. The ensuing impact on emergency personnel has received little attention. The present study aimed to explore the experiences and perspectives of emergency personnel responding to the opioid crisis in NH, with a focus on their views toward people who use opioids.

Methods: Thirty-six emergency personnel (emergency department clinicians, $n = 18$; emergency medical service providers, $n = 6$; firefighters, $n = 6$; and police officers, $n = 6$) in 6 New Hampshire counties were interviewed about their experiences responding to overdoses and their perspectives on individuals who use opioids. Directed content analysis was used to identify themes in the transcribed, semistructured interviews. The results were reviewed for consensus.

Results: Several categories of themes were identified among emergency personnel's accounts of their overdose response experiences and perspectives, including varied degrees of compassion and stigma toward people who use opioids; associations between compassion or stigma and policy- and practice-related themes, such as pre-hospital emergency care and the role of emergency departments (EDs); and primarily among personnel expressing compassion, a sense of professional responsibility that outweighed personal biases.

Conclusions: Despite the magnitude of the ongoing opioid crisis, some emergency personnel in New Hampshire have sustained or increased their compassion for people who use opioids. Others' perspectives remain or have become increasingly stigmatizing.

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The associations of compassion and stigma with various policy- and practice-related themes warrant further investigation.

KEYWORDS

compassion, drug overdose, emergency departments, emergency responders, opioid crisis, qualitative research, social stigma

1 | INTRODUCTION

1.1 | Background

Drug overdoses are the leading cause of death in the United States (US) for those under age 50 years,¹ contributing to reductions in US life expectancy in recent years.² New Hampshire has consistently ranked among the states with the highest rate of drug overdose deaths³ and remains among the top 3 states with the most overdose deaths per capita from synthetic opioids, including fentanyl and its analogs.⁴

The opioid overdose crisis in New Hampshire has resulted in increased encounters with the emergency response system. Opioid-related emergency department (ED) visits in New Hampshire doubled from 2011 to 2017 and remained about 70% higher compared to 2011 through the end of 2019.^{5,6} Likewise, emergency medical service (EMS) encounters in New Hampshire in which naloxone, an opioid antagonist, was administered more than tripled from 2012 to 2016 and have consistently been more than double 2012 levels in subsequent years.^{6,7}

1.2 | Importance

Despite the substantial rise in overdose-related responses, the ensuing impact on emergency personnel, including ED clinicians, EMS providers, firefighters, and police officers, has received limited attention. The relatively few studies of emergency personnel have shown that they have high confidence in treating overdoses⁸ but that the crisis is taking a notable emotional toll on them.⁸⁻¹¹ Better understanding of emergency personnel's experiences and perspectives may help to improve care for individuals who use opioids, develop more effective policy-level responses, and ensure sufficient support for emergency personnel themselves.

1.3 | Goals of this investigation

This investigation is part of a larger qualitative project on the opioid crisis in New Hampshire that aimed to learn from emergency personnel and people who use opioids to better inform policy and practice.^{8,12-14} The present exploratory study was conducted to gain a deeper understanding of emergency personnel's opinions of people who use opioids, their experiences relevant to overdose response policy and practice, and the associations of their opinions with policy- and practice-related themes.

2 | METHODS

2.1 | Study design, setting, and participants

Purposive, self-selection, and snowball sampling were used to recruit participants between November 2016 and January 2017. The study was advertised through individual email contact, flyers, and word of mouth. Three ED providers, 1 EMS provider, 1 firefighter, and 1 police officer, all at least 18 years of age, were recruited from each of 6 New Hampshire counties: Cheshire, Grafton, Hillsborough, Rockingham, Strafford, and Sullivan. Hillsborough County was targeted as the epicenter of the opioid crisis in New Hampshire, and the 5 additional counties provided greater representation across the state. Each participant designated their primary affiliation because some served in multiple roles (eg, all firefighters were licensed EMS providers; some EMS providers also served in EDs). As the research team recruited the target sample of 36 participants, 7 individuals declined to participate for unspecified reasons. The final sample of 36 emergency personnel consisted of 18 ED providers: ED leadership ($n = 7$), non-leadership physicians ($n = 4$), nurses ($n = 5$), a paramedic ($n = 1$), and a physician assistant ($n = 1$); and 18 first responders: EMS providers ($n = 6$), firefighters ($n = 6$), and police officers ($n = 6$).

2.2 | Measures

The interview guide focused on experiences responding to opioid overdoses, perspectives on substance use treatment, New Hampshire state policy, and fentanyl; the present study pertains primarily to questions from the overdose response section of the guide (Appendix 1). The guide was semistructured, allowing for probing questions following participants' responses. The interview questions were created to help address gaps in knowledge identified through previous research with New Hampshire stakeholders, including emergency personnel, treatment providers, and policymakers.¹⁵ A 12-item demographic and professional history survey was also created for the study (Appendix 2).

2.3 | Procedure

Potential participants contacted, or were contacted by, the research team via telephone or email. Participants were offered a study information document and provided verbal consent, completed the

demographic and professional history survey, and then interviewed with a research team member, all within a single session.

ECS, SA, SAM, and SKM conducted the semistructured, in-depth interviews. All were full-time researchers trained in substance use-related qualitative interviewing. The research team included female and male interviewers who did not have prior relationships with most interviewees. A few research team members had previous contact with a few participants, which helped to establish rapport.

Interviewers shared the study rationale with participants during the verbal consent process before the interview. Each participant was interviewed in a private, one-on-one setting by telephone or in person at Dartmouth College or the interviewee's workplace, depending on participant preference. Interviews lasted 1 hour and were audio recorded and transcribed verbatim. Field notes were taken as needed during each interview, and a brief summary was written immediately after the interview's conclusion. No repeat interviews were conducted. Participants did not provide comments on transcripts or findings.

Each participant was assigned a unique study identifier; no identifying information was retained to protect confidentiality. Participants were compensated with a \$50 gift card. This study was approved by the Dartmouth College Committee for the Protection of Human Subjects.

2.4 | Analysis

Directed content analysis was used as the guiding analytic methodology; this systematic approach allows for the examination of patterns in text by building on previous work¹⁶—in this case, the research with New Hampshire stakeholders noted previously.¹⁵ The analysis followed a similar 5-stage, iterative process to that used by Sasson et al. (2015)¹⁷: (1) developing a coding tree, (2) coding the data, (3) describing the primary categories, (4) connecting categories into themes, and (5) explaining the associations among themes. Coding domains were primarily identified in advance based on the interview guide, though some codes were derived from the data. The coding tree consisted of 11 primary codes, representing the main themes of the interview guide, with subcodes used to further parse the data.

AM, ECS, OW, and SAM coded the interview transcripts. The analysts began by independently coding and then collectively reviewing 2 transcripts to reach consensus on definitions, revising the coding tree as needed. The team subsequently coded the remaining transcripts, noting any uncertainties during weekly group discussions. ECS, OW, SAM, SB, and SKM analyzed the coded data. Two team members analyzed text segments within each code to determine themes, and these analyses were discussed weekly with the full analytic team. ATLAS.ti version 7¹⁸ was used for coding and subsequent analysis. In an effort to achieve data saturation, the research team enrolled the full sample and analyzed all transcripts to ensure confirmation of findings and representation of dissenting voices.

SAM conducted, and ECS and SKM reviewed, analyses of emergency personnel's perspectives of individuals who use opioids. Participants were grouped based on their self-reported views toward people who use opioids as well as self-reported changes in views over time. After consolidating more nuanced categories (eg, "suspicious" and "cyni-

The Bottom Line

Understanding the effects of the ongoing opioid epidemic on emergency personnel may lead to improved responses that support patients and providers. In this study, qualitative interviews and directed content analysis were used to explore experiences and perspectives among emergency department clinicians, emergency medical service (EMS) clinicians, firefighters and police towards people who use opioids. Personnel expressed varied degrees of compassion and stigma, though personnel frequently expressed a sense of professional responsibility that outweighed personal biases.

cal" were grouped with "stigmatizing"), the analysts determined that the in vivo descriptors "compassionate" (wanting to alleviate suffering after witnessing another's distress¹⁹), "stigmatizing" (negatively biased toward individuals who use opioids²⁰), and "conflicted" (some degree of both compassion and stigma) best fit the data. Based on this classification, the analysts conducted further qualitative analyses to determine whether participants endorsing various policy- and practice-related themes differed in compassion and stigma toward individuals who use opioids. For these analyses, participants who reported compassionate perspectives or more compassion over time were grouped as compassionate; participants who expressed conflicted or stigmatizing views were grouped together as relatively less compassionate toward people who use opioids. An association was noted between a theme and compassion (or conflict/stigma) if at least 75% of participants endorsing a theme expressed compassionate (or conflicted/stigmatizing) views. See Figure 1.

Descriptive statistics were calculated for the demographic and professional history survey using Stata version 14.²¹ The methods and results are reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.²²

3 | RESULTS

3.1 | Characteristics of study participants

Participants were primarily middle-aged, white, non-Hispanic males. Although demographic data are not available specifically for New Hampshire emergency personnel, these demographics are largely representative of New Hampshire with the exception of gender.²³ These emergency personnel had been employed for a median of 11 years (first quartile: 6.5; third quartile: 20), though this varied by professional group, with ED providers reporting the least time employed in their profession (median: 7.5 years; first quartile: 3; third quartile: 10) and EMS providers reporting the most (median: 22 years; first quartile: 7; third quartile: 24). All participants had responded to overdoses, with some estimating many hundreds of overdose responses. All participants, except the police officers, had administered naloxone (Table 1).

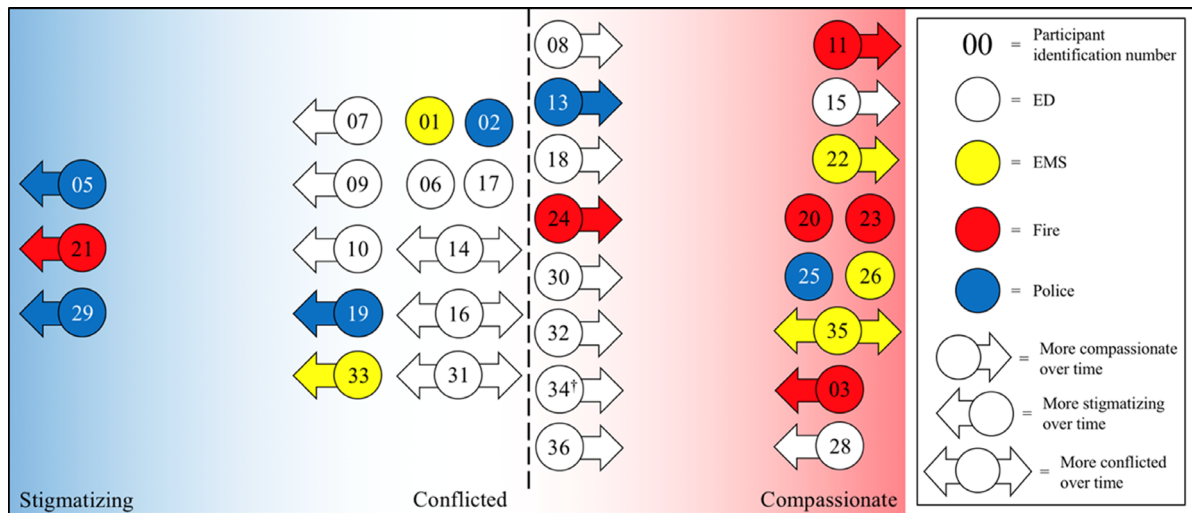


FIGURE 1 Emergency personnel's self-reported perspectives of individuals who use opioids, with self-reported changes over time.

† Participant 34–ED stated neutral rather than conflicted views about individuals who use opioids before describing changes in views over time.

Note: The vertical line signifies the dichotomy for purposes of the analysis of associations between perspectives about individuals who use opioids and policy- and practice-related themes. Participants to the right of the line reported compassionate views or more compassion over time; they were grouped as compassionate in the analysis. Participants to the left of the line expressed conflicted or stigmatizing views about people who use opioids. Participants 04–EMS, 12–ED, and 27–ED were not able to be classified regarding views toward individuals who use opioids. These 3 participants are neither represented in the figure nor included in the analyses associating participant perspectives (compassionate versus conflicted/stigmatizing) with policy- and practice-related themes.

Abbreviations: ED, emergency department; EMS, emergency medical services.

TABLE 1 Participant demographics and professional history

Demographics	Emergency Department (n = 18)	Emergency Medical Services (n = 6)	Fire (n = 6)	Police (n = 6)
Age, years, median (Q1, Q3)	45 (34, 49)	46 (38, 54)	44.5 (38, 51)	40.5 (37, 47)
Gender				
Female	6 (33.3%)	0 (0%)	0 (0%)	1 (16.7%)
Male	12 (66.7%)	6 (100%)	6 (100%)	5 (83.3%)
Race, n (%)				
Black/African American	1 (5.6%)	0 (0%)	0 (0%)	0 (0%)
White	16 (88.9%)	6 (100%)	6 (100%)	6 (100%)
Multiracial	1 (5.6%)	0 (0%)	0 (0%)	0 (0%)
Ethnicity, n (%)				
Hispanic or Latino	2 (11.1%)	0 (0%)	0 (0%)	0 (0%)
Not Hispanic or Latino	16 (88.9%)	6 (100%)	6 (100%)	5 (83.3%) ^a
Years employed in the profession, median (Q1, Q3)	7.5 (3, 10)	22 (7, 24)	18.75 (13, 27)	15.5 (11, 20)
Estimated number of overdose responses, median (Q1, Q3)	100 (50, 200)	87.5 (50, 300)	57.5 (40, 80)	62.5 (30, 88)
Estimated events administering naloxone, median (Q1, Q3)	25 (15, 50)	31.5 (20, 250)	30 (25, 50)	0 (0, 0)
Average naloxone doses per patient, median (Q1, Q3)	1.5 (1, 2)	1.75 (1, 2)	1.5 (1, 2)	N/A

Abbreviations: n, number of participants; Q1, first quartile (25th percentile); Q3, third quartile (75th percentile).

^aOne police officer did not report ethnicity.

3.2 | Main results

The research team identified several categories of themes among emergency personnel's descriptions of their perspectives and experiences responding to overdoses: varied degrees of compassion and

stigma toward people who use opioids along with changes in views over time; associations between compassion or stigma and various policy- and practice-related themes; and primarily among personnel expressing compassion, a focus on professionalism that superseded personal biases (Table 2).

TABLE 2 Categories, themes, subthemes, and representative quotes

Category/theme/subtheme	Representative quote (participant identification number, primary affiliation)
Category 1: Varied degrees of compassion and stigma regarding people who use opioids	
Compassionate	"They [people who use opioids] are human. They are our patient[s]. They have a problem. They're not abusing the system. They have a problem, but that's what we get paid for. We get paid to fix the problem." (23, Fire)
<i>Addiction as a disease</i>	"I'm not here to judge people. I'm just here to do my job. People have different types of problems, and I think... it's [opioid use disorder] just another disease." (20, Fire)
Stigmatizing	"My personal feeling is that I feel like we do a lot. I feel like we really push ourselves to help these people. To help them, I know that I've personally sat down and had these heart-to-hearts with these people, knowing inside that they're probably not listening to me. They're probably just nodding their head and going 'yep, yep, yep,' and they're gonna go out and use again.... It is an absolutely horrible disease that I don't wish upon anybody. But you're still making conscious choices. You're still making conscious decisions to use." (14, ED)
<i>Addiction as an excuse for lack of responsibility</i>	"I understand the idea that this is a medical diagnosis and a problem, but I also do think that there's a significant component of personal choice in this. I think in some ways the push to push this all onto medicine, or onto biology, removes that responsibility. I think in some ways the problem is self-made in the end." (16, ED)
Conflicted	"Some people who have [opioid use disorder] also have very, very poor overall decision-making skills. Their lives are unstable. They're spending the money on whatever else, but many patients... simply got into it because of whatever reason—legal prescription, maybe a physical abuse as a kid, something like that—and they were wired for addiction, and it sucked them in. I have a lot of empathy for a lot of patients, although there are some I still think there is a behavioral component. I know that's a complicated answer." (30, ED)
<i>More understanding of some groups than others</i>	"I get the people that are on pills... from injuries or whatever and transition to heroin. Obviously, I can see that... With the person that just decides to do heroin because they've done marijuana, they've done [cocaine], and now they're going to progress to heroin—you're an absolute idiot." (29, Police)
Category 2: Changes in views over time regarding people who use opioids	
More compassionate	"If anything, it's [my view toward people who use opioids] become more understanding because I've seen the addiction in more people now... I have even more belief in the fact that I'm there to help them get the help they need." (22, EMS)
More stigmatizing	"You get frustrated with people that you see time and again, and you don't really feel as much compassion. It's a little bit harder to muster sometimes, I think, just from the sheer number of times that you see them, and you just want to see them get better, and they're not." (31, ED)
More conflicted	"I struggle with this internally, I think.... I don't know how much sympathy I have in the end, but I still try to empathize with them, I guess." (16, ED)
Category 3: Themes more frequently cited by participants expressing compassionate views regarding people who use opioids	
Difficulty of losing patients	"I went to an overdose this past year where I had to wake up the guy's kid, who is the same age as my own, and tell him that his dad was dead, and then had to usher him out of the house so that he didn't see his dead father laying on the floor. That resonates with me." (13, Police)
Convincing patients to accept transport to ED	"Part of our standard protocol for anybody who doesn't want to go is to ensure that we've explained to them the benefits of accepting care and transport to the hospital and the potential risks if they refuse further care and transport to the hospital.... If we're trying to convince someone to go to the hospital, we will use whatever resources are available to us." (28, ED)
Category 4: Themes more frequently cited by participants expressing conflicted or stigmatizing views regarding people who use opioids	
Misaligned expectations about ED services	"I think that people are under the misunderstanding sometimes that if you come into the emergency room that we're going to be able to help you all the way through it [recovery from a substance use disorder], and we just can't. That's not our job.... Our job is to stabilize and treat the immediate injury and either discharge you home with follow-up with your primary provider or admit you to the hospital for further care and evaluation." (14, ED)
Category 5: Themes discussed compassionately regardless of general opinions about people who use opioids	
Personal connections	"On a personal note, a few years ago, we had an EMS provider in our system that developed some chronic back pain, got hooked on opiates, and actually became kind of a drug seeker in our institution, and ended up being found dead of a heroin overdose. Stuff like that definitely sticks to you." (26, EMS)
"Success stories"	"Actually, the very first time that I met a really great success story was at this CPR/[naloxone] training that my town put on... She was a beautiful, 30-year-old woman... She was doing a little too much partying at some of these events and got hooked on heroin and overdosed multiple times. But she's been clean now for 7 years... She tells a great story of what it was like for her to be in that black hole, and what it was like to sit in therapy and completely not even care... Finally, somewhere along the way, it just sort of clicked, she said.... That was, honest to God, the first time in my entire career that I've met someone that appears to have come out." (33, EMS)

(Continues)

TABLE 2 (Continued)

Category/theme/subtheme	Representative quote (participant identification number, primary affiliation)
Category 6: Professional responsibilities outweighed personal biases about people who use opioids	
Professional responsibilities outweighed personal biases about people who use opioids	"We don't treat anybody differently... A patient is a patient... We're going to be as nice and as kind to you as we possibly can because we don't to dissuade you from calling back when there's another problem." (04, EMS)
<i>ED providers want patients to stay for observation</i>	"For the most part, I'm just grateful when a patient is amicable and allows us to observe them for the 2 hours so they don't get hurt." (36, ED)
<i>Naloxone allows for second chances</i>	"I think that it's [naloxone] an amazing medicine that is really giving people a second chance, and you hope that it's a second chance to save a life and not do it [overdose on opioids] again." (07, ED)

Abbreviations: CPR, cardiopulmonary resuscitation; ED, emergency department; EMS, emergency medical services.

Note: Categories are bolded. Themes are in plain text. Subthemes are italicized.

3.2.1 | Varied degrees of compassion and stigma regarding people who use opioids

Emergency personnel shared differing levels of compassion and stigma regarding individuals who use opioids (Figure 1). Many expressed "compassion": "This is important to me, just because of how it's affected our community. ... I just tend to be a little bit compassionate and want to make sure that we're moving people towards help" (participant identification number: 11; primary affiliation: Fire). This group often acknowledged opioid use disorder as a disease, describing people who use opioids as "decent human beings with a terrible addiction" who have "a brain hack" that "hurt[s] your software" (15, ED).

Others conveyed "stigma" (06, ED), such as having "no respect for anybody that would just decide to do this [an opioid] as a recreational drug and then becomes addicted" (29, Police). Even when acknowledging that "addiction is a disease" that "some people are more susceptible to... like any other disease," some participants with stigmatizing views claimed that "you can only blame so much on the disease. And then we start using it as a crutch and as an excuse for why you're not getting help" (14, ED).

Most, however, felt "conflicted" (02, Police) in their opinions: "[Opioid use] affects us for the way that we screen patients, both that we want to help them, and yet, at the same time, we have some degree of suspicion of the patients" (18, ED). Participants with conflicted or stigmatizing views about individuals who use opioids sometimes expressed their perspectives through dichotomies, such as prescription versus recreational use or socioeconomic hierarchies. For example, "Years ago... [opioids were] an inner-city drug. It was homeless people. ... But now that I see it working in upper-class homes and families that are great families, it definitely is scaring me" (33, EMS).

One participant stated that they were neutral in their perspective about individuals who use opioids. All 4 professional groups and all 6 counties had representatives expressing compassionate and conflicted/stigmatizing perspectives.

3.2.2 | Changes in views over time regarding people who use opioids

When asked whether their views toward people who use opioids had changed over time, participants again varied widely in their answers.

In response to the New Hampshire opioid crisis that they perceived as "overwhelming" (03, Fire) and "a true epidemic" (05, Police), some emergency personnel reported becoming more compassionate: "Typically, when you see a lot of something, you become kind of immune to it, and I think in this particular case, and I don't know why it is, it kind of went from being "oh gosh, another addict," to you kind of start to realize that every single one... is somebody's child. It's somebody's family member. I think, actually, our empathy has increased, as opposed to decreased, or at least in my case it has" (08, ED). For some this shift toward compassion was more subtle, such as trying "harder not to allow any biases that I have to affect the way that I interact with patients" who use opioids (34, ED).

Others reported becoming increasingly "numb" (03, Fire), "cold" (33, EMS), and "unfortunately... kind of immune" (29, Police) through the crisis. This was sometimes related to repeated interactions with individuals: "I think it just makes us cynical. ... I don't know if jaded is the right word, but the issue is just basically how many times can you see the same patient and go through the same speech and try to keep a positive attitude?" (09, ED). A few personnel felt more conflicted over time, and some reported that their views had not changed.

3.2.3 | Themes more frequently cited by participants expressing compassionate views regarding people who use opioids

Participants with compassionate views more frequently told stories of losing patients, especially young people, including "a mid-20-something girl... Everyone loved her. It crushed everyone in the community around here" (25, Police). One participant with a notably compassionate perspective shared that the death of a coworker's child due to an opioid overdose had inspired the participant's career: "In his honor, I am trying to give back" (15, ED).

When discussing the standard protocol of transporting patients to the ED after overdose treatment in the field, emergency personnel expressing compassion were the only participants to mention that they attempted to convince resistant individuals to accept transport to the ED in order to "get them the care that they need. ... There's all different ways of getting them up there [to the ED]. The idea is just to get them up there" (24, Fire).

3.2.4 | Themes more frequently cited by participants expressing conflicted or stigmatizing views regarding people who use opioids

A few of the emergency personnel with conflicted or stigmatizing views spoke about misaligned expectations between ED clinicians and people who use opioids. These interviewees shared that the ED is not a substance use treatment facility: "I think a lot of patients come to the emergency department thinking that we can solve all their problems. [They] come to the hospital... assuming that we have the resources to do this. ... They're looking for help, and I don't have [any help] to give them" (16, ED). Although each of these participants noted that the EDs with which they are affiliated have social workers, crisis counselors, or peer coaches as well as phone numbers patients can call for connections to substance use treatment, none of the participants expressing frustration about the purpose of EDs mentioned the availability of ED-initiated medications for opioid use disorder (MOUD).

3.2.5 | Themes discussed compassionately regardless of general opinions about people who use opioids

Regardless of the general opinions they disclosed about people who use opioids, emergency personnel were nearly universally compassionate when discussing personal connections to substance use: "[There was a] 16-year-old that I used to coach in football. He [uses substances] right now. ... He doesn't call me Officer so-and-so. He calls me Coach so-and-so still to this day. It absolutely breaks my heart" (05, Police).

Similarly, participants spoke compassionately about those they deemed successful in their recovery from opioid use disorder: "I can recall a patient... who overdosed repeatedly... I can tell you that I have seen her since then, and she has been sober for a year and... her life isn't dictated by how she's going to get her next dose of opioids. ... I wish we heard more about that. I wish it was represented more. ... It really is nice to actually have someone who still is in that community, that still frequents that emergency department... who actually turned it around" (08, ED).

3.2.6 | Professional responsibilities outweighed personal biases about people who use opioids

Many emergency personnel shared that they prioritized professional responsibilities over any personal biases when responding to overdoses: "I'm a medical professional. My job is to fix them medically. It's not my job to judge why or if or when or who. ... Who knows? Maybe the eighth time is the one where he finally figures it out, and that's our job to continue to do that" (22, EMS). Of the 15 participants who shared this sentiment, 9 expressed compassion in their opinions about individuals who use opioids, and the others shared conflicted rather than stigmatizing viewpoints. No police officers mentioned suppressing their biases and carrying out their duties non-judgmentally, though this may be due in part to the small subsample of 6 officers.

A prime example of this sense of professional responsibility over personal biases can be seen in conflicts between emergency personnel and patients who arrive in the ED after an overdose reversal. Despite noting that patients typically want to leave the ED as soon as possible, many emergency personnel discussed their desire "to keep somebody in the emergency [department]" until discharge is safe "because the [naloxone] can wear off, and they can become somnolent and... their respirations can slow down" (07, ED). This desire to keep patients safe in the ED was expressed not only by interviewees who shared compassionate views but also by those who had stronger biases against individuals who use opioids.

Likewise, when asked about their views on naloxone, a few participants who expressed conflicted views about people who use opioids acknowledged that naloxone "is a life-saving medication that... essentially buys that patient another opportunity to make the decision to do what needs to be done to deal with their addiction" (16, ED).

4 | LIMITATIONS

The findings of the present study are exploratory and cross-sectional and should be used for hypothesis generation rather than drawing conclusions. Additionally, the present study consists of a relatively small, non-probability sample of emergency personnel from 1 rural state in the United States with a predominantly white, non-Hispanic population. The ED subsample was disproportionately male, perhaps in part because of selective recruitment of some ED leadership and physician positions, which are male dominated nationwide,²⁴⁻²⁶ including in New Hampshire.²⁷ The findings may not be transferable to other parts of the country, particularly more urban and racially and ethnically diverse areas. Similar studies in different settings will help determine the transferability of the present study's results. The findings are weighted toward ED perspectives given the relative sample sizes of the professional groups. These small subsamples also limited intergroup comparisons.

Some participants may have been uncomfortable fully disclosing their opinions to the research team. However, the depth and range of responses, including many participants sharing negative views about individuals who use opioids, provide some evidence against social desirability bias. Analysts were not masked to participants' professions when coding the transcripts and conducting the subsequent analyses, which may have influenced their analytic decisions. The dichotomization of compassionate versus conflicted/stigmatizing views in the analysis of associations with other themes is a weakness; this decision was made to ensure groups of a sufficient size. The 75% threshold for these associations was somewhat arbitrary but was set relatively high to be conservative.

5 | DISCUSSION

New Hampshire, like many states throughout the United States, continues to withstand an opioid crisis that has taken hundreds of thousands

of lives nationwide over the past several years.²⁸ To help address the gap in knowledge regarding the impact of the crisis on emergency personnel, the present study analyzed the experiences and perspectives of ED and EMS providers, firefighters, and police officers in New Hampshire, with a focus on their opinions of people who use opioids.

Participants revealed diverse perspectives about individuals who use opioids, and most expressed conflicted views, sharing some degree of both stigma and compassion. Stigma is a well-documented problem with respect to substance use across many populations,²⁹ including among emergency personnel.³⁰ For some participants, stigma was closely tied to repeated interactions with individuals. Although compassion and stigma are not opposing poles on a single continuum, these constructs tend to be at odds by definition and based on existing substance use research.^{31–33} Future studies of emergency personnel should examine the association between compassion and stigma with respect to substance use, including potential root causes of individual and collective views and possible explanations for changes in each construct over time at levels ranging from individual to societal.

Interviewees who expressed compassionate views described substance use disorders as diseases and were more likely to share stories about losing patients. Interviewees who expressed conflicted or stigmatizing views, on the other hand, sometimes dismissed addiction as an excuse for poor behaviors and were more understanding of some groups of people who use opioids than others, such as those with prescription rather than recreational use histories. These findings corroborate previous research on ED and EMS personnel⁹ and law enforcement officers³⁴ and reinforce the message that some emergency personnel may benefit from enhanced training on the biological, psychological, and social components of substance use disorders.³⁵

Among those engaged in prehospital emergency medical care, the only emergency personnel to mention trying to convince resistant patients to accept transport to the ED after an overdose were those who expressed compassionate perspectives. It is possible that only personnel expressing compassion found this noteworthy and that regardless of compassion or stigma, personnel attempt to convince patients to accept ED transport. However, if personnel with compassionate viewpoints are more inclined to persuade or are more successful in their persuasion, it means the likelihood of a patient's survival may depend in part on the level of compassion of the responders who arrive at the scene. Evidence from a different interview study of EMS providers and people who use opioids corroborates the finding that increased compassion and decreased stigma from providers may be critical to the acceptance of ED transport.³⁶ The degree to which provider compassion and stigma influence practice patterns and patient outcomes should be investigated further.

Participants who shared conflicted or stigmatizing opinions noted more frequently that patients had unrealistic expectations that the ED could serve as a treatment program. However, some promising substance use treatment initiatives begin in EDs, such as buprenorphine treatment and referral.^{37–39} MOUD (ie, buprenorphine, methadone, and naltrexone), sometimes in combination with psychosocial and behavioral therapies, are the most effective and evidence-based treatments for opioid use disorder,^{40,41} yet stigma with respect to MOUD

is pervasive.^{42,43} Although it may be prudent to help align patients' expectations with the purpose of EDs, providing ED clinicians with additional resources to offer patients, including ED-initiated MOUD, may empower these personnel to overcome the sense of helplessness some expressed because of the limited substance use-related services they could offer. This potential relation between emergency personnel's frustration and available resources for patients with substance use problems is worthy of further research. Additional studies should explore whether ED and out-of-hospital emergency personnel's perspectives on MOUD are associated with the availability of ED- or EMS-initiated MOUD in their service areas, whether the introduction of MOUD initiatives corresponds to changes in perspectives on MOUD over time, and whether perspectives on MOUD are correlated within teams, organizations, and regions.

Regardless of general viewpoints about people who use opioids, emergency personnel shared compassion when discussing personal connections who have experienced substance use issues as well as the gratifying experience of learning about stories they considered successful. This aligns with previous research suggesting that personalization is related to compassion and that depersonalization is related to stigma.^{44–48} Future studies should explore in greater depth the potential associations and any moderating variables between personal connections to substance use and compassion, compassion fatigue, and stigma.

Despite disclosing a variety of opinions about individuals who use opioids, many emergency personnel expressed an approach of professionalism over biases. This was supported by interviewees' thoughts on naloxone as an opportunity for second chances and their urging for patients to remain in the ED for further observation after an overdose regardless of their personal views on people who use opioids. However, even though the compassion-versus-stigma percentage for this theme did not meet the analytic threshold of 75%, most of the emergency personnel who prioritized their professional responsibilities over any personal biases expressed compassion in their views about individuals who use opioids, and the remaining participants expressed conflicted rather than overtly stigmatizing opinions. It is unsurprising that personnel expressing greater compassion might be more likely, and perhaps better able, to prioritize professionalism over biases compared with those expressing greater stigma. This interplay among compassion, stigma, and professionalism could have important implications. A previous study of people bereaved by substance-related deaths found that "cold professionalism"—that is, professionalism without expressions of compassion—was perceived in much the same way as stigma.³¹ Future research should examine emergency personnel's professionalism, compassion, and stigma with respect to the perceptions and outcomes of people who use opioids.

Although several police officers expressed some degree of compassion, none of the police interviewees mentioned an approach of repressing their biases and performing their duties non-judgmentally. This may be a spurious finding due to the small sample, and the lack of mention does not necessarily mean that police do not feel a sense of professional responsibility that outweighs personal biases. However, it was notable that police were the only professional group absent

in a theme that was identified among 15 participants. If this finding is replicated, an area to investigate further is whether the lack of police endorsing a non-judgmental approach may be connected to the long history of criminalizing substance use in the United States and police officers' historical role as law enforcers rather than medical providers.⁴⁹ None of the police officers in this sample had administered naloxone, so the perspectives of this stakeholder group may be shaped by their distinct role at overdose events. As police are increasingly asked to transition their focus toward providing linkages to treatment and promoting overdose awareness in response to the opioid crisis,^{50,51} research examining best practices for training police officers on overdose response is critical.³⁴ Whether police officers' and other emergency personnel's perspectives are related to their frequencies of overdose response is also worth additional exploration.^{51,52}

In summary, emergency personnel are faced with a crisis that has increased their encounters with individuals who use opioids. Although stigma is an enduring problem, some emergency personnel in this study had compassionate perspectives of people who use opioids and prioritized their professional responsibilities over any personal biases. Compassion and stigma appear to be related to a number of themes relevant to policy and practice, including prehospital emergency care, the role of EDs, and training on addiction. The findings provide several avenues for future research on emergency personnel responding to the ongoing US opioid crisis, focused not only on personnel themselves but also on the systems and contexts in which they operate.

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CONFLICTS OF INTEREST

None

AUTHOR CONTRIBUTIONS

Lisa A. Marsch and Andrea Meier conceived the study and obtained research funding. Samantha Auty, Stephen A. Metcalf, Sarah K. Moore, and Elizabeth C. Saunders recruited and enrolled participants and collected the data. Andrea Meier, Stephen A. Metcalf, Elizabeth C. Saunders, and Olivia Walsh coded the interview transcripts. Sarah Y. Bessen, Stephen A. Metcalf, Sarah K. Moore, Elizabeth C. Saunders, and Olivia Walsh analyzed the coded data. Stephen A. Metcalf and Elizabeth C. Saunders performed the descriptive statistical analyses. Stephen A. Metcalf drafted the manuscript, and all authors contributed substantially to its revision. Stephen A. Metcalf takes responsibility for the paper as a whole. All authors have approved the final manuscript.

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SUPPORTING INFORMATION

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