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"Let me hear what you're needing": exploring how HIV providers conceptualize patient-provider interactions with people with HIV who use drugs using a harm reduction framework

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Abstract

Background: In addition to structural interventions such as syringe services and naloxone distribution, harm reduction (HR) is also a *relational* approach to care encompassing principles such as patient autonomy and pragmatism that can be implemented in healthcare teams to improve outcomes for people with HIV (PWH) who use drugs. Evidence suggests that using a relational HR framework to operationalize care for PWH who use drugs may improve the patient-provider relationship, thus positively impacting HIV outcomes. We previously found that negative attitudes toward people who use drugs are negatively associated with acceptance of HR; however, little is known about how HIV providers conceptualize the patient-provider relationship with PWH who use drugs.

Objectives: The aim of this study was to describe the ways healthcare workers (HCWs) characterize interactions with PWH who use drugs and if these characterizations reflect relational HR or missed opportunities to improve the patient-provider relationship.

Design: We used a qualitative descriptive design to characterize HCWs' descriptions of their interactions with PWH who use drugs.

Methods: We interviewed providers ($n = 23$) working at three HIV clinics in the United States to assess their interactions with patients. Providers included anyone who had worked at their respective clinic for ⩾1 year and who had face-to-face contact with patients (e.g., front desk staff, nurses, physicians, and social workers). Data were coded thematically via Dedoose.

Results: We discovered that HCWs characterize positive patient-provider interactions that both reflect HR principles and may not align with the principles of HR. Examples include when patients appear comfortable with and trusting of their provider, when patients feel heard by their provider, and when providers feel they are responsive to patient needs. However, other HCWs described positive interactions as counter to relational HR.

Conclusion: HCW descriptions of positive interactions in line with relational HR in their conceptualization of patient-provider interactions with PWH who use drugs have the potential to guide efforts in increasing the acceptability of HR in HIV care. Given evidence showing HR improves outcomes for those who use substances, findings suggest missed opportunities to incorporate relational HR into the patient-provider relationship in HIV primary care settings.

Registration: NCT05404750.

Keywords: harm reduction, harm reduction principles, HIV, patient-provider relationship, people who use drugs, relational harm reduction

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Background

People who use drugs, including injection drugs, experience significant health inequities, including disproportionate HIV incidence, higher risk for HIV transmission, increased rates of hepatitis C, poorer retention in care, and increased risk for opioid overdose.[1–7] For people with HIV (PWH) who use drugs, these inequities are often exacerbated by pervasive healthcare stigma, a known primary cause for existing health inequities across the HIV continuum of care.[8–11] A systematic review of stigma among health professionals toward people who use drugs found that HCWs generally had negative attitudes toward patients who use drugs, and negative attitudes toward those patients who used illicit drugs were "strongly negative."[10] Healthcare worker (HCW) stigma toward PWH who use drugs leads to poor clinical outcomes, including increased rates of depression, lack of treatment completion, suboptimal care, lack of retention in care, decreased adherence to antiretroviral therapy, and lower rates of viral suppression.[9–13] A 2020 editorial urges HCWs to provide compassionate, non-stigmatizing care to people who use drugs, noting the alternative may exacerbate drug use.[14]

We found preliminary evidence that relational harm reduction approaches improve clinical outcomes for PWH including those who use drugs,[15,16] and that harm reduction may reduce experiences of stigma in healthcare settings.[17] In addition to *structural* interventions such as syringe services and naloxone distribution, harm reduction is also a *relational* approach to care encompassing principles such as patient autonomy and pragmatism that can be implemented in healthcare teams to improve outcomes for PWH who use drugs. Previously, we established six relational harm reduction principles tailored for healthcare settings (e.g., humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination), outlining methods for clinicians to implement and deliver relational harm reduction care.[15] While relational harm reduction is an innovative framework for HCWs to utilize, additional research is needed to elucidate how HCWs can implement relational harm reduction in practice.

There are opportunities to address healthcare stigma-related health inequities within the patient-provider relationship.[18] A positive and supportive patient-provider relationship can foster trust, enhance communication, and ensure that patients feel valued and understood,[19] and there is evidence that patient-provider relationship factors are associated with patient satisfaction and adherence.[20] On the other hand, anticipated stigma in healthcare settings is associated with lower trust in providers.[11] Evidence suggests that adopting a relational harm reduction framework can significantly improve this relationship for PWH who use drugs, thus positively impacting HIV outcomes and disclosure of drug use by patients.[15,21,22] Given that researchers of HCW stigma have underscored the need for training and education for HCWs to improve knowledge and skills in working with people who use drugs, understanding how HCWs interact with PWH who use drugs and characterize those interactions is crucial.[10]

We previously found that attitudes toward people who use drugs are negatively associated with acceptance of HR;[23] however, little is known about how HIV providers characterize the patient-provider relationship with PWH who use drugs. Using the six relational harm reduction principles we previously developed provides a framework by which we explore how HCWs operationalize relational harm reduction in the patient-provider relationship. Thus, the aim of this study is to describe the ways HCWs characterize interactions with PWH who use drugs and if these characterizations reflect relational harm reduction or missed opportunities to improve the patient-provider relationship using relational harm reduction.

Methods

Study design and setting

As part of a mixed methods parent study (Impact of harm reduction care in HIV clinical settings on stigma and health outcomes for PWH who use drugs (R01DA054832)), we explored HIV HCWs' knowledge and use of structural and relational harm reduction to inform intervention development.[24] This paper presents findings from the qualitative phase conducted during Aim 1 to complement and contextualize our quantitative phase using electronic surveys, which explored HCW attitudes regarding harm reduction acceptability, HCW stigma of HIV and drug use, and PWH who use drugs. We utilized qualitative semi-structured interviews with HCWs at HIV clinics in the United States using a qualitative

descriptive approach[25,26] to elucidate HCWs' perceptions, attitudes, and experiences related to working with PWH who use drugs, as well as their attitudes toward and experiences with harm reduction.

Study sites included one HIV clinic in Birmingham, Alabama (University of Alabama at Birmingham 1917 Clinic), and two HIV clinics in Pittsburgh, Pennsylvania (Allegheny Health Network's Positive Health Clinic and University of Pittsburgh Medical Center's HIV/AIDS Programme). Both cities experience disproportionate HIV and opioid overdose incidence rates, while some structural harm reduction tools such as syringe service programs (SSPs) are only legal in Pittsburgh, not Alabama.

Sample and recruitment

We conducted qualitative interviews with HCWs at all three study sites from November 2022 to March 2023 to explore how HCWs characterize patient-provider interactions. We purposively sampled HCWs who (1) worked at one of the three sites for at least 1 year and (2) had face-to-face contact and engagement with PWH or people who use drugs (PWUD) with increased likelihood of HIV acquisition, including clinicians, dietitians, research coordinators, social workers, service coordinators, and front desk staff. Internal site champions contacted HCWs at each site via internal electronic messaging with information about the interviews and a link to schedule an interview with a study team member via Microsoft Bookings.

Data collection

In keeping with our framework, we used a semi-structured interview guide including questions regarding relational aspects of care, including what typical interactions with patients look like, how often HCWs discuss topics outside of clinical care with their patients, and how they learn about their patients' lives. The guide was developed iteratively and reviewed by our study team, which includes HCWs; four researchers experienced with qualitative research with PWH who use drugs conducted interviews. To assess relational harm reduction within the patient-provider relationship, we asked three interview questions regarding HCWs' characterization of patient-provider interactions to explore how HCWs view patient-provider interactions: (1) *Tell me about a really good interaction with a patient?* (2) *Tell me about a really bad interaction with a patient?* (3) *In your mind, what is the ideal relationship between patients and providers?* We also collected demographic information, including racial and ethnic identities, job titles, and years of practice providing care to PWH who use drugs. All interviews were conducted via HIPAA-compliant Zoom and lasted between 30 and 60 min (average = 45 min). Interviews were audio-recorded using Zoom and transcribed verbatim.

Analysis

Interviews were coded thematically in Dedoose using a team-based deductive approach. One MPI, 1 Co-I, one research coordinator, and one research assistant proficient in qualitative methods completed all coding with supervision by the other MPI and Co-I. Detailed descriptions of our analysis of transcripts, including codebook development, the resolution of coding discrepancies, and achievement of code saturation, are provided elsewhere.[27] Using relational harm reduction principles as our analytic framework (Table 1)[15] to explore the ways the characterizations of patient-provider interactions aligned with the principles of relational harm reduction, we reviewed interactions that were coded using harm reduction principles subcodes, the provider stigma codes, and/or the code for descriptions of patients or interactions with patients that were antithetical to harm reduction. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines were consulted during the study conduct and preparation of this manuscript (Supplemental Material).[28]

Results

Sample characteristics

We interviewed 23 HCW roles across the 3 study sites representing 11 different HCW roles, encompassing a wide range of HCW positions and types of care within HIV clinics, including clinicians, nurses, registered dietitians, pharmacists, front desk workers, medical technicians, therapists/counselors, benefits coordinators, medical social workers, clinical research coordinators, and physician assistants. A full analysis of HCW roles is provided elsewhere.[27] Roughly half of participants came from Birmingham ($n = 12$) and the other half from Pittsburgh ($n = 11$). The

Table 1. Relational harm reduction principles and definitions.

Humanism	• Providers value, care for, respect, and dignify patients as individuals • It is important to recognize that people do things for reason; harmful health behaviors provide some benefit to the individual
Pragmatism	• None of us will ever achieve perfect health behaviors • Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum
Individualism	• Every person presents with their own needs and strengths • People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options
Autonomy	• Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices about medications, treatment, and health behaviors
Incrementalism	• Any positive change is a step toward improved health, and positive change can take years • It is important to understand and plan for backward movement
Accountability without termination	• Patients are responsible for their choices and health behaviors • Patients are not "fired" for not achieving goals • Individuals have the right to make harmful health decisions

majority of participants identified as white, non-Hispanic (64%), and cisgender women (82%), with approximately one-third of the sample having less than 5 years of experience working with PWH (36%).

HCW characterizations of patient-provider interactions

Participants described myriad ways in which they conceptualize both positive and negative patient-provider interactions that can be characterized across the relational harm reduction continuum. Participants often felt that negative interactions occurred when patients were depressed, sad, expressing suicidality, or needing psychiatric care. Behavioral issues such as being rude, aggressive, or inappropriate toward providers were also seen as negative interactions. Interestingly, some providers also described negative interactions as being when patients are "stagnant" in their health and/or circumstances, indicating a lack of positive movement (incrementalism); one provider said they do not like having "the same conversation over and over again" with the same patient. Finally, some providers described instances in which patients do not want providers' "help" or education as interactions they considered to be negative, suggesting a lack of individually tailored care (i.e., individualism).

Participants also discussed a range of interactions they characterized as positive. Some HCWs described positive interactions as those in which patients appear comfortable with and trusting of the HCW, conversations that are easy or pleasant, when patients feel heard by the HCW, and when HCWs feel they are responsive to patient needs, all in line with relational harm reduction principles (e.g., humanism, individualism, pragmatism). However, other HCWs described positive interactions as counter to relational HR principles such as autonomy, describing "positive" or "good" interactions as those in which patients acquiesce to providers' expectations, or make provider-directed behavioral changes. Thus, we discovered that HCWs characterize positive patient-provider interactions across the relational harm reduction continuum, with some quotes illustrating strong relational harm reduction and others illustrating ways in which even "good" interactions may not align with the principles of harm reduction.

Positive patient-provider interactions across relational harm reduction principles

To illustrate the ways in which HCWs characterize and describe positive patient-provider interactions in ways that incorporate relational harm reduction or highlight missed opportunities, we selected six participant quotes that best

exemplified the use or lack of each relational harm reduction principle, which also demonstrate the overlap and flexibility of the principles.

Autonomy

> It's great when patients come back and they say, "Hey. You know, doctor, I wasn't ready to stop using drugs, but I appreciate that you respected my autonomy and gave me sterile supplies." They feel like you care more, and then you feel like, "Oh, God. I feel like I'm actually doing my job," even though that's not necessarily something that you've been taught in your medical training. HCW, Pittsburgh

This first HCW characterized positive patient-provider interactions as those in which patients feel their autonomy is respected and they receive the care they want or ask for. In line with the relational harm reduction principle of *autonomy*, patient care is driven by the patient; in this case, the patient made their choice regarding appropriate treatment (i.e., structural harm reduction strategies such as sterile supplies) and the HCW respected that choice, providing those supplies. Likewise, this HCW highlights the importance of *pragmatism* within patient-provider interactions by supporting the patient's goals, including when those goals do not include abstinence. Some HCWs felt that interactions in which they supported patients' goals regarding substance use and were responsive to patients' needs were particularly positive. Similarly, interactions related to patient trust and comfort with HCWs, especially when related to disclosing stigmatized behaviors such as drug use and "life chaos," were frequently cited as positive by HCWs.

Pragmatism

> When patients understand that "everything. . . can be okay and will be okay as long as you are compliant, you listen, and do what's asked of you to be done. . . Myself or the doctors wouldn't ask you to do anything that we wouldn't do ourselves, you know, if, the shoe was on the other foot. Um, and just to reassure them that we're here to help you, you know? We're not here to harm you, so, um– and gaining that trust. HCW, Pittsburgh

This HCW characterized positive interactions with patients as those in which the patient is "compliant." Interactions are seen as positive when patients do what HCWs tell them to do and make HCW-directed behavior changes. This quote conflicts with, rather than supports, relational harm reduction principles. Rather than providing a range of supportive approaches (i.e., *pragmatism*) and sharing decision-making with the patient (i.e., *autonomy*), the HCW sees positive interactions as those in which HCWs are in complete control. A foundation of relational harm reduction included in the principle of *accountability without termination* is that individuals are ultimately responsible for their health outcomes and have the right to make harmful health decisions; "noncompliance" or backward movements are not penalized within this framework.

Individualism

> I'm not gonna try to push things on you that you don't really want. And so I'm often like, "Okay. Where are you at? Let me hear what you're needing. What can I do to assist?" HCW from Birmingham

This HCW describes perfectly the relational harm reduction principle of *individualism* as an example of a positive patient-provider interaction. In this example, needs are assessed with each individual patient, and there is no universal assistance provided; rather, care and support are determined with the patient based on their current experiences, needs, and health goals (i.e., *autonomy*). The principle of *humanism* is also highlighted in the above quote; we see that patient services provided by HCWs are responsive to patient needs rather than solely determined by the HCW, a characterization of a positive patient-provider interaction shared by other HCWs in our sample. HCWs' acceptance of patients' decisions regarding treatment and interventions is a positive patient-provider interaction well aligned with relational harm reduction. Another HCW suggested asking patients "How do you view [those recommendations]?" or "Do you think you can get there?" or even "If you don't think you can, where do you think you can get?" when providing health recommendations associated with improved health outcomes to involve patients in the decision-making process with providers.

Humanism

> A positive interaction is "someone that will, you know, actually cite– first of all, I value honesty, and I will let all the patients know that. I expect nothing but the truth. Um, we do have a few that, you know, try to get by with fudging that a little bit. But I,

> um– you know, I just always tell them, "I will always be honest and respectful with you, as long as we get the same." HCW, Birmingham

The quote above illustrates the perception of positive patient-provider interactions as those in which patients are honest with HCWs. Here, the HCW suggests that they will be honest and respectful (i.e., *humanism*), but only if the patient is honest and respectful to the HCW. Relational harm reduction principles of *humanism* and *pragmatism* underscore the importance of care approaches that do not include moral judgments and acknowledge that no one can ever achieve "perfect" health behaviors, including disclosure of stigmatizing health behaviors, to HCWs. Our sample frequently cited patients' comfort with and trust of the HCW as positive patient-provider interactions, highlighting the importance of this theme in patient-provider relationships.

Incrementalism

> I think I, I– accomplishing a– some type of goal. Um, so it could be something small, something big. Um, anything that's kinda stepping forward in their health, even if they're– they are already healthy, um, making sure that they maintain their health. So however big or small that goal would be, um, that makes– that's something that would make me happy. HCW, Pittsburgh

In this quote, the HCW's characterization of positive change, including small steps forward in the patient's health, as a positive interaction is in line with the relational harm reduction principle of *incrementalism*. Practicing relational harm reduction includes celebrating any positive changes, big or small, and recognizing that these changes take time. For example, another HCW discussed how some patients start "doing well very quickly," while for others it takes time to see positive change with many small and large steps along the way. HCWs can celebrate any positive change through positive reinforcement with the patient; at the same time, HCWs can be prepared for future harmful health decisions, backward movement, and plateaus knowing that perfect health is unachievable (i.e., *pragmatism*). Some HCWs in our sample stated that seeing patients make small positive changes over time provides the most satisfaction in the patient-provider relationship for HCWs, compared to specific moments in time related to the patients' health.

Accountability without termination

> I think the best interactions are just where the patient is still as comfortable just disclosing all the things that they otherwise would find stigmatizing in a traditional medical setting. So, I mean, I have some patients who'll tell me, "My, my aunt died last week. I've been overtaking my Suboxone. I've been self-medicating. I ran out early, and then I went into withdrawal. So then I had to go get some dope." And, you know, they'll just disclose all, all of their history and their life chaos. . . I think they realized that because we have a harm reduction approach, "[My doctor's] not gonna kick me outta the clinic." HCW, Birmingham

This HCW believes that patients' knowledge that they will not be fired from their clinic as punishment for harmful health behaviors allows patients to disclose substance use and other historically stigmatized behaviors to their HCWs, highlighting the connection between *accountability without termination* and stigma reduction for PWH who use drugs in clinical settings. HCWs can make the practice of *accountability without termination* known to patients, which may support patient trust and improve patient-provider relationships. Institutionalizing this practice as clinic policy is encouraged for clinics that serve PWH who use drugs. For example, one HCW said that their clinic only "fire" patients from their clinic who threaten violence toward staff or other patients, demonstrating the feasibility of implementing such a practice at the clinic level.

Discussion

Using relational harm reduction, HCWs describe negative patient-provider interactions in ways that acknowledge that patient-provider relationships with PWH who use drugs can be complicated or imperfect.[27] Despite inherent challenges with maintaining strong patient-provider relationships, positive interactions with patients are common and HCWs in our sample often characterized those interactions in overlapping ways, indicating that some HCWs share how they conceptualize both positive and negative interactions with patients.

Many HCWs characterize positive patient-provider interactions in ways that align with relational harm reduction principles. Examples include interactions that are respectful and understanding (i.e., humanism), when providers

provide care when abstinence is not the patient's goal (i.e., pragmatism), when the HCW learns and/or acknowledges the patient's unique needs (i.e., individualism), when patients and HCWs share decision-making about patient care (i.e., autonomy), when HCWs celebrate small positive changes (i.e., incrementalism), and when patients trust HCWs enough to share harmful or stigmatizing health behaviors with the HCWs (i.e., accountability without termination). These descriptions highlight the ways in which HCWs operationalize and incorporate relational harm reduction into their interactions with patients, thereby strengthening the patient-provider relationship. Given that, so few HCWs in our sample had any harm reduction training,[27] alignment with relational harm reduction principles is encouraging.

While HCWs identified many examples of positive patient-provider interactions, many of which align with relational harm reduction principles, there are still gaps. Interestingly, we found that some HCWs characterize positive interactions with patients as those in which the interactions are antithetical to relational harm reduction. For example, some HCWs described interactions in which the patient is "compliant" or makes HCW-directed behavioral changes as positive, which misses opportunities to incorporate relational harm reduction principles of *pragmatism* and *autonomy* into the patient-provider relationship. These findings indicate that some HCWs providing care to PWH who use drugs may not be incorporating relational or structural harm reduction into their care.

Given evidence showing relational harm reduction improves outcomes for people who use drugs, our findings suggest missed opportunities to incorporate relational harm reduction principles into the patient-provider relationship in the HIV primary care settings where our study took place. These opportunities highlight the need for increased and long-term structural and relational harm reduction training for HCWs, including training for roles such as front desk staff and dieticians that may not historically be included in harm reduction training for HCWs at HIV clinics. HCWs' descriptions of positive interactions with PWH who use drugs that align with relational harm reduction offer insight into potential training. For example, quote number three provides an important language for conversations with patients: "Let me hear what you're needing." This framing centers and individualizes the patient, acknowledges that the HCW wants to listen to the patient, and highlights that the patient ultimately understands their own needs best. Given the evidence that peer-to-peer physician coaching improves professional satisfaction and work engagement,[29] incorporating relational harm reduction principles into this intervention strategy for physicians may support improved patient-provider relationships.

Likewise, results highlighting gaps in relational harm reduction care for PWH who use drugs at these clinics provide opportunities to reframe and/or improve interactions with patients. For example, the expectation that patients are always honest and predicating HCWs' honesty on patients' behavior could be reframed to maintain the importance of honesty while integrating principles of humanism and pragmatism. Similarly, it is possible to reframe the value of patient honesty in the above example, instead of working to create patient-provider interactions that respect and dignify patients regardless of their health disclosures, thereby creating environments in which patients may feel more comfortable disclosing stigmatizing behaviors, health "mistakes," or backward movement. We will use these findings to develop an intervention to increase relational harm reduction in healthcare settings and pretest the intervention for feasibility and acceptability with a diverse group of community collaborators, including patients, HCWs, and harm reduction experts.

Our study is not without limitations, including a purposive sample of HCWs from just three HIV clinics in urban settings with the majority of participants being white women. Thus, results may not reflect HCWs generally across the U.S. Further, providers opted into interviews, which may introduce selection bias. A traditional qualitative framework reporting results using qualitative themes would perhaps provide a broader view of the qualitative data; however, our primary method of assessing relational harm reduction using six salient quotes offers the opportunity to succinctly explore how HCWs characterize interactions across the relational harm reduction continuum. Despite these limitations, this research provides insight into attitudes and perspectives from HCWs in two cities in different regions with differing political and social climates (e.g., SSPs are legal in Pittsburgh but not in Birmingham); differences in the structural stigma of drugs,

people who use drugs, and harm reduction may influence HCWs' beliefs, which is captured in these data. While many of our participants were clinicians and nurses, our sample included a wide range of HCWs, including front desk staff and benefits coordinators, who are historically excluded from research related to patient-provider relationships and the healthcare-based stigma of PWH who use drugs. This work highlights the need to further understand the ways in which HCWs' attitudes and perceptions of interactions with PWH who use drugs affect the patient-provider relationship, and how we can further incorporate relational harm reduction into patient-provider relationships.

Conclusion

Many HCWs in this study identified clear examples of relational harm reduction in practice, as well as missed opportunities. In addition to increased relational harm reduction training for HCWs in HIV clinics, the ways in which HCWs operationalize relational harm reduction in this study can guide us in identifying possible interventions to improve relational harm reduction within the patient-provider relationship. While not every interaction with a patient in any clinic will feel good or perfect, considering how HCWs can move forward along the relational harm reduction continuum may improve patient-provider relationships, thus improving health outcomes for PWH who use drugs.

Declarations

Ethics approval and consent to participate

This study was approved via expedited review by the University of Pittsburgh Institutional Review Board (STUDY2109000). All participants provided verbal informed consent to participate in individual interviews because the research presented no more than minimal risk of harm to subjects and interviews were conducted virtually.

Consent for publication

Not applicable.

Author contributions

Stephanie L. Creasy: Conceptualization; Formal analysis; Methodology; Project administration; Writing – original draft.

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Competing interests

The authors declare that there is no conflict of interest.

Availability of data and materials

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Supplemental material

Supplemental material for this article is available online.

References

1. Bonn M, Palayew A, Bartlett S, et al. Addressing the syndemic of HIV, Hepatitis C, overdose, and COVID-19 among people who use drugs: the potential roles for decriminalization and safe supply. *J Studies Alcohol Drugs* 2020; 81(5): 556–560.
2. Mathers BM, Degenhardt L, Phillips B, et al. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet* 2008; 372(9651): 1733–1745.
3. Mathers BM, Degenhardt L, Ali H, et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet* 2010; 375(9719): 1014–1028.
4. Dasgupta S. Injection practices and sexual behaviors among persons with diagnosed HIV infection who inject drugs—United States, 2015–2017. *MMWR* 2019; 68: 653–657.
5. Bulsara SM, Wainberg ML and Newton-John TR. Predictors of adult retention in HIV care: a systematic review. *AIDS Behavior* 2018; 22: 752–764.
6. Hartzler B, Dombrowski JC, Williams JR, et al. Influence of substance use disorders on 2-year HIV care retention in the United States. *AIDS Behavior* 2018; 22: 742–751.
7. Perlman DC and Jordan AE. The syndemic of opioid misuse, overdose, HCV, and HIV: structural-level causes and interventions. *Current HIV/AIDS Rep* 2018; 15: 96–112.
8. Brener L, Hippel WV, Kippax S, et al. The role of physician and nurse attitudes in the health care of injecting drug users. *Subst Use Misuse* 2010; 45(7–8): 1007–1018.
9. Gilchrist G, Moskalewicz J, Slezakova S, et al. Staff regard towards working with substance users: a European multi-centre study. *Addiction* 2011; 106(6): 1114–1125.
10. van Boekel LC, Brouwers EPM, van Weeghel J, et al. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug Alcohol Depend* 2013; 131(1): 23–35.
11. Budhwani H, Yigit I, Ofotokun I, et al. Examining the relationships between experienced and anticipated stigma in health care settings, patient–provider race concordance, and trust in providers among women living with HIV. *AIDS Patient Care STDs* 2021; 35(11): 441–448.
12. Kay ES, Rice WS, Crockett KB, et al. Experienced HIV-related stigma in health care and community settings: mediated associations with psychosocial and health outcomes. *JAIDS* 2018; 77(3): 257–263.
13. Biancarelli DL, Biello KB, Childs E, et al. Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug Alcohol Dependence* 2019; 198: 80–86.
14. Volkow ND. Stigma and the toll of addiction. *New Eng J Med* 2020; 382(14): 1289–1290.
15. Hawk M, Coulter RW, Egan JE, et al. Harm reduction principles for healthcare settings. *Harm Reduction J* 2017; 14: 1–9.
16. Hawk MFM, Coulter R, Creasy SL, et al. "There's More to HIV than a Pill": operationalizing and measuring a harm reduction approach to HIV clinical care. In: *22nd International AIDS conference*. Amsterdam, Netherlands: Poster Presentation, 2018.
17. De Leon BAR, Coulter RWS, Friedman MR, et al. Unveiling the connection: HIV stigma, substance use stigma, and HIV healthcare providers' acceptance of harm reduction. In: *25th International AIDS conference*. Munich, Germany: Poster Presentation, 2024.
18. Kamimura A, Higham R, Rathi N, et al. Patient–provider relationships among vulnerable patients: the association with health literacy, continuity of care, and self-rated health. *J Patient Exp* 2020; 7(6): 1450–1457.
19. Jenerette CM and Mayer DK. *Patient-provider communication: the rise of patient engagement*. Paper presented at: Seminars in oncology nursing, 2016.
20. Beck RS, Daughtridge R and Sloane PD. Physician-patient communication in the primary care office: a systematic review. *J Am Board Family Pract* 2002; 15(1): 25–38.
21. O'Brien TC, Feinberg J, Gross R, et al. Supportive environments during the substance use disorder epidemic in the rural United States: provider support for interventions and expectations of interactions with providers. *Social Sci Med* 2022; 294: 114691.
22. Eton DT, Ridgeway JL, Linzer M, et al. Healthcare provider relational quality is associated with better self-management and less treatment burden in people with multiple chronic conditions. *Patient Prefer Adherence* 2017; 11: 1635–1646.
23. Ahmed R, Coulter RWS FM, Kay ES, et al. Attitudes of HIV healthcare providers towards people who use drugs and acceptance of harm reduction strategies. *Under Review*.

24. Kay ES, Creasy S, Batey DS, et al. Impact of harm reduction care in HIV clinical settings on stigma and health outcomes for people with HIV who use drugs: study protocol for a mixed-methods, multisite, observational study. *BMJ Open* 2022; 12(9): e067219.

25. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000; 23(4): 334–340.

26. Sandelowski M. What's in a name? Qualitative description revisited. *Res Nurs Health* 2010; 33(1): 77–84.

27. Kay ES, Creasy SL, Townsend J, et al. A qualitative exploration of health care workers' approaches to relational harm reduction in HIV primary care settings. *Harm Reduction J* 2024; 21(1): 97.

28. Tong A, Sainsbury P and Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007; 19(6): 349–357.

29. Kiser SB, Sterns JD, Lai PY, et al. Physician coaching by professionally trained peers for Burnout and well-being: a randomized clinical trial. *JAMA Netw Open* 2024; 7(4): e245645.