WITHHOLDING CARE THROUGH TIME AND THE POLITICS OF RELATIONAL DIGNITY: PERCEPTIONS OF MORAL TRIAGE IN EMERGENCY DEPARTMENT ENCOUNTERS WITH PEOPLE WHO USE DRUGS IN ONTARIO, CANADA

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Background

Emergency departments (EDs) are a critical point of care for people who use drugs (PWUD), yet many report experiences of stigma, dismissal, and prolonged waiting. While triage systems are designed to prioritize clinical acuity, research suggests that perceptions of drug use and patient credibility may shape care experiences, potentially influencing wait times and symptom interpretation. We examine how temporal allocation and relational treatment shape ED encounters for PWUD.

Methods

As part of a participatory action research project conducted in partnership with the Ontario Network of PWUD, we interviewed PWUD (n=51) who visited one of four Ontario EDs in the past two years. Participants were 53% men, 43% women, and 4% non-binary, with a mean age of 42 years. Interviews, conducted between January and June 2024, were analyzed using reflexive thematic analysis to explore patterns related to waiting, dismissal, relational interactions, and perceived legitimacy in ED encounters.

Results

Participants frequently described waiting and inaction as abandonment, particularly when drug use was known/assumed. Many interpreted care delays, symptom dismissal, and heightened surveillance as reflecting moral judgment rather than clinical prioritization. Conversely, encounters featuring relational gestures (e.g., clear explanations, respectful tone, humor, matter-of-fact professionalism) were described as affirming and legitimate. Accounts suggested that visits not perceived as drug-related more often involved routine relational care, whereas drug-use-framed encounters involved temporal marginalization, diagnostic dismissal, and care disengagement, including leaving the ED before treatment.

Conclusion

Temporal allocation and relational tone appear to shape PWUD experience of emergency care; narratives suggest emerging forms of ‘moral triage’ when clinical prioritization intersects with stigma and structural vulnerability. Improving ED equity may require attention beyond policies and training to the interactional

and temporal practices that signal legitimacy and deservingness. Integrating navigators with lived experience into ED care may improve communication, reduce stigma, and support PWUD navigating emergency services.