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Hospitals as a 'risk environment': An ethno-epidemiological study of voluntary and involuntary discharge from hospital against medical advice among people who inject drugs

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ABSTRACT

People who inject drugs (PWID) experience high levels of HIV/AIDS and hepatitis C (HCV) infection that, together with injection-related complications such as non-fatal overdose and injection-related infections, lead to frequent hospitalizations. However, injection drug-using populations are among those most likely to be discharged from hospital against medical advice, which significantly increases their likelihood of hospital readmission, longer overall hospital stays, and death. In spite of this, little research has been undertaken examining how social–structural forces operating within hospital settings shape the experiences of PWID in receiving care in hospitals and contribute to discharges against medical advice. This ethno-epidemiological study was undertaken in Vancouver, Canada to explore how the social–structural dynamics within hospitals function to produce discharges against medical advice among PWID. In-depth interviews were conducted with thirty PWID recruited from among participants in ongoing observational cohort studies of people who inject drugs who reported that they had been discharged from hospital against medical advice within the previous two years. Data were analyzed thematically, and by drawing on the 'risk environment' framework and concepts of social violence. Our findings illustrate how intersecting social and structural factors led to inadequate pain and withdrawal management, which led to continued drug use in hospital settings. In turn, diverse forms of social control operating to regulate and prevent drug use in hospital settings amplified drug-related risks and increased the likelihood of discharge against medical advice. Given the significant morbidity and health care costs associated with discharge against medical advice among drug-using populations, there is an urgent need to reshape the social–structural contexts of hospital care for PWID by shifting emphasis toward evidence-based pain and drug treatment augmented by harm reduction supports, including supervised drug consumption services.

Introduction

Current estimates suggest that more than 15 million people worldwide regularly inject drugs (Mathers et al., 2008). The health sequelae of injection drug use can be severe, and include infectious disease acquisition and other direct complications of injecting (e.g., overdose). As a consequence, people who inject drugs (PWID) suffer from disproportionately high levels of HIV/AIDS (Mathers et al., 2008) and hepatitis C (HCV) infection (Aceijas & Rhodes, 2007) that, together with high rates of non-fatal overdose (Warner-Smith, Darke, & Day, 2002), injection-related soft tissue infections (Cooper et al., 2007; Lloyd-Smith et al., 2008), and other co-morbidities common among this population, lead to frequent hospitalizations (Gebo, Diener-West, & Moore, 2003; Kerr et al., 2005; Palepu et al., 2001). As a result, PWID are admitted to hospital significantly more often than the general age-adjusted population (Kerr et al., 2005).

There is also clear evidence that PWID are one of the populations most likely to be discharged from hospital against medical advice (Anis et al., 2002; Choi, Kim, Qian, & Palepu, 2011; Jeremiah & Stein, 1995; Yong et al., 2013). For our purposes, discharges against medical advice are understood to be inclusive of discharges occurring among patients who have left hospital prior to

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completing treatment (whether they have notified hospital staff they are leaving or not), as well as those who have been involuntarily discharged prior to completing treatment (e.g., discharge for breach of hospital policies). Discharges from hospital against medical advice among PWID can exacerbate health complications, and this population is significantly more likely to be readmitted for the same condition and have longer eventual hospital stays than those who have completed treatment (Anis et al., 2002; Choi et al., 2011; Glasgow, Vaughn-Sarrazin, & Kaboli, 2010; Hwang, Li, Gupta, Chien, & Martin, 2003). Furthermore, those discharged against medical advice are at an increased risk of mortality (Choi et al., 2011; Yong et al., 2013), with one Canadian study finding that this population is approximately three times as likely to die in the year following their initial discharge (Choi et al., 2011).

Whereas epidemiological analyses of hospital admissions and discharge data have identified crude demographic risk factors for departures against medical advice among PWID, including female gender, younger age, and Aboriginal ancestry (Anis et al., 2002; Chan et al., 2004), comparatively less attention has been paid to contextual forces underlying this phenomenon. Several studies have noted that these departures are most likely to occur in the days immediately surrounding the disbursement of social assistance payments (Anis et al., 2002; Riddell & Riddell, 2006), and that these may be mitigated to some degree by providing access to inpatient methadone maintenance treatment (Chan et al., 2004). However, the lack of attention to the potential role of intersecting social, structural, and environmental forces operating within hospitals in shaping discharges against medical advice among PWID means that these explanations are incomplete. In addition, these individual-level explanations primarily attribute discharges against medical advice to 'active drug use' in a manner that risks locating responsibility for these outcomes solely with PWID. This overlooks social and structural–environmental characteristics of hospitals that potentially lead to discharges against medical advice, and creates a missed opportunity to modify these environmental characteristics to promote better retention of PWID in care.

This research gap is particularly striking given more than a decade of evidence demonstrating the need for increased attention to 'risk environments' – that is, social and physical settings in which factors exogenous to the individual (i.e., social situations, structures, and places) interact to produce or reduce drug-related harms (Rhodes, 2009; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). The emergence of the 'risk environment framework' has focused attention on how the interplay between physical, social, economic, and policy factors operating across the micro-, meso-, and macro-environmental levels produce harm among PWID (Rhodes, 2002, 2009). Concepts of structural vulnerability and everyday violence have further proven instructive in framing the suffering experienced by drug-using populations (Fairbairn, Small, Shannon, Wood, & Kerr, 2008; Shannon et al., 2008). Structural vulnerability refers to how social arrangements embedded in the organization of society render particular populations disproportionately vulnerable to harm (Quesada, Hart, & Bourgois, 2011). Everyday violence refers to the normalization of suffering within any particular context due to the contextual forces that render it invisible (Scheper-Hughes, 1992). Together, these concepts give focus to how the structural context of drug use (e.g., drug criminalization) produces vulnerability to an array of drug- and health-related harms, and reflect dominant power structures that normalize these harms as the natural consequences of drug use. Sorting out the complex contextual forces operating within the risk environments of people who use drugs is critical to understanding their role in shaping health outcomes – in this case, discharges against medical advice – and informing social–ecological interventions.

While qualitative research into the experiences of injection drug-using populations in hospital settings is limited, and has yet to systematically explore the experiences of those discharged against medical advice, it has generated preliminary insights into the social forces operating within the hospital 'risk environment' (Berg, Arnsten, Sacajiu, & Karasz, 2009; Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002; Neale, Tompkins, & Sheard, 2008). In an ethnographic study exploring patient–physician interactions in an American urban teaching hospital, Merrill et al. (2002) outlined how 'mutual mistrust' frames the hospital care of PWID. Whereas physicians attributed their difficulty in managing pain to the fear of being 'deceived' by 'drug-seeking' patients and the lack of clinical protocols for pain management among injection drug-using populations, PWID viewed physicians with suspicion and believed that their treatment was primarily shaped by discrimination (Merrill et al., 2002). Whether or not this, together with other contextual factors, plays a role in discharges from hospital against medical advice warrants further attention.

These issues are of considerable relevance in Vancouver, Canada, the site of a longstanding injection drug use epidemic and home to an estimated 15,000 PWID (McInnes et al., 2009). The majority of the city's injection drug-using population will visit an emergency department each year (Kerr et al., 2005), with approximately 17% of these visits resulting in hospitalization (Fairbairn et al., 2011; Palepu et al., 2001). In Vancouver, PWID are covered by universal, publicly-funded health care insurance. However, while comprehensive harm reduction services, including a supervised injection facility, are integrated into the local public health system and local hospitals struggle with the optimal management of hospitalized PWID, hospitals generally operate under abstinence-based drug use policies (Providence Health Care, N.D; Vancouver Coastal Health, 2008). While abstinence-based policies in part reflect anti-drug laws, they are also framed as necessary in promoting patient and staff safety. In addition, prescribing principles promoted by the British Columbia College of Physicians and Surgeons regarding prescription opioids have been primarily developed for non-drug-using populations, and warn against prescribing opioids to 'high-risk' populations (British Columbia College of Physicians and Surgeons, 2012). Past research has shown that PWID in this setting are frequently discharged from hospital against medical advice (Anis et al., 2002; Choi et al., 2011; Palepu et al., 2001), and in one urban teaching hospital account for more than half of such discharges (Choi et al., 2011).

We undertook this ethno-epidemiological study to explore how intersecting social, structural, and environmental forces shape the experiences of PWID in hospitals settings and contribute to discharges against medical advice. We were particularly concerned with the role of abstinence-based drug policies in hospital settings in framing the social and structural–environmental contexts of hospital care, pain management practices, and in-hospital drug use. Finally, we aimed to identify ways in which the hospital 'risk environment' could be modified to minimize the potential for adverse outcomes, including discharges against medical advice.

Methods

This ethno-epidemiological study was undertaken in connection with two ongoing prospective cohort studies: the Vancouver Injection Drug Users Study (VIDUS) and the AIDS Care Cohort to Evaluate Exposure to Survival Services (ACCESS). These cohort studies include more than 2000 current and former drug users, and their methods have been described in detail elsewhere (Strathdee et al., 1997; Wood, Montaner, et al., 2003). Ethno-epidemiology seeks to uncover how social meanings and contexts influence