Waiting room ambience and provision of opioid substitution therapy in general practice

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Abstract

Objective: To assess whether patients receiving opioid substitution therapy (OST) in general practice cause other patients sufficient distress to change practices — a perceived barrier that prevents general practitioners from prescribing OST.

Design, setting and participants: A cross-sectional questionnaire-based survey of consecutive adult patients in the waiting rooms of a network of research general practices in New South Wales during August – December 2009.

Main outcome measures: Prevalence of disturbing waiting room experiences where drug intoxication was considered a factor, discomfort about sharing the waiting room with patients being treated for drug addiction, and likelihood of changing practices if the practice provided specialised care for patients with opiate addiction.

Results: From 15 practices (eight OST-prescribing), 1138 of 1449 invited patients completed questionnaires (response rate, 78.5%). A disturbing experience in any waiting room at any time was reported by 18.0% of respondents (203/1130), with only 3.1% (35/1128) reporting that drug intoxication was a contributing factor. However, 39.3% of respondents (424/1080) would feel uncomfortable sharing the waiting room with someone being treated for drug addiction. Respondents were largely unaware of the OST-prescribing status of the practice (12.1% of patients attending OST-prescribing practices [70/579] correctly reported this). Only 15.9% of respondents (165/1037) reported being likely to change practices if theirs provided specialised care for opiate-addicted patients. In contrast, 28.7% (302/1053) were likely to change practices if consistently kept waiting more than 30 minutes, and 26.6% (275/1033) would likely do so if consultation fees increased by $10.

Conclusions: Despite the frequency of stigmatising attitudes towards patients requiring treatment for drug addiction, GPs' concerns that prescribing OST in their practices would have a negative impact on other patients' waiting room experiences or on retention of patients seem to be unfounded.

Globally, opioids cause more harm than any other illicit drug.[1] To minimise this harm, the United Nations (UN) advocates accessible, affordable, evidence-based treatments including opioid substitution therapy (OST). However, only 8% of intravenous opioid users globally are receiving OST from treatment services.[1]

General practice has been found to be an ideal setting for safe and effective provision of OST.[1-4] Potential benefits include improved patient capacity, accessibility, cost-effectiveness, reintegration, recognition and management of analgesic misuse, and care for patients with medical and psychiatric comorbidities.[3-6] However, there is a major shortage of OST prescribers in Australia,[4,5,7] resulting in long waits to commence treatment. In our health service, we have observed that waits of over 2 years are not uncommon, with some juveniles and adults who received OST in correction centres unable to continue their treatment upon release.

There has been much academic interest in understanding why doctors do not deliver OST. People dependent on illicit or prescription opioids[8] have been described as complex, undesirable, manipulative and damaging to the doctor's own mental health, family life and work performance.[3-6,9,10] Their financial effect may be "slow economic suicide" through being time-consuming, too chaotic to keep appointments and requiring increased staffing.[5,6,9-11] Objections may be faced from the community and colleagues.[9,10] Patients receiving OST are thought to invite denigration of the doctor and the practice, causing other patients to drift away.[5,6,9-11] They may be threatening, disruptive or disturbing to other patients in the waiting room (WR).[9-11] General practitioners perceive patients requiring OST as presenting a risk of violence, and that an effective risk management approach is to avoid taking them on.[9,11,12] In general, GPs make little distinction between treated and untreated opioid-dependent individuals.[10]

These perceived barriers remain untested, and calls have been made for more practice-based research.[4-6] A major measurable barrier is the perception that disturbance, worry or violence may result from mixing patients receiving OST with other patients in the WR.

We sought to establish how often patients have experienced unsettling episodes due to drug intoxication in general practice WRs. We also sought to identify associations of negative attitudes towards sharing a WR with patients being treated for drug addiction and of intention to change general practices if the practice provided treatment for opiate addiction.

Methods

This was a cross-sectional questionnaire-based study of adult patients in general practice WRs. The study was conducted in practices of the Hunter New England Central Coast Network of Research General Practices in New South Wales. All 16 practices in the network were invited and agreed to participate. Practice managers provided demographic information about the practices. The Australian Standard Geographical Classification – Remoteness Area was used to describe the rurality of the practice location.[13]

Ethics approval was obtained from the University of Newcastle Human Research Ethics Committee (reference no. H-2009-0095).

Study instrument

A questionnaire was constructed to assess patients' attitudes towards, and experiences of, fellow patients receiving OST, compared with fellow patients with diabetes, attention deficit hyperactivity disorder, faecal or urinary incontinence, severe depression or anxiety, schizophrenia, and alcohol misuse. Participants were asked to note if they had a personal or family history of any of the nominated problems. The Socio-economic Indexes for Areas (SEIFA) Index of Relative Socio-economic Disadvantage[14] was used to describe respondents' socioeconomic status, based on residential postcode.

Outcomes

Primary outcomes were the prevalence of any disturbing or unsettling WR experiences where drug intoxication was considered a contributing factor, discomfort about sharing a WR with patients being treated for drug addiction, and likelihood of changing general practices if the practice provided specialised care for patients with opiate addiction. A secondary outcome was prevalence of the perception that general practice was a suitable place to treat patients with drug addiction.

To contextualise expressed likelihood of changing general practices, participants were also asked if they would be likely to change practices if the practice increased its consultation fee (by $10 or $20) or consistently kept them waiting (for more than 15 or 30 minutes).

Procedures

During three randomly selected half-day sessions over a 2-week period (between August and December 2009), staff at each practice invited consecutive patients presenting for appointments to participate. Patients were given a pack containing an information statement, a questionnaire and a reply-paid envelope. Exclusion criteria were: age under 18 years, significant acute medical or psychiatric illness, and written English skills insufficient to complete the questionnaire. Responses were anonymous and either returned to a box in the WR or mailed to the researchers by reply-paid post.

1 General practice and patient demographics

Variable	No. (%)*
Practices	**15**
Location	
Major city (RA 1)	7
Inner regional (RA 2)	8
Prescribing status	
At least one accredited OST provider	8
No accredited OST providers	7
Full-time equivalent (FTE) general practitioners, mean ± SD; median (range)	5.4 ± 2.1; 5.0 (1.0–9.6)
Patients†	**1138**
Age in years, mean ± SD; median (range)	52.7 ± 19.8; 53.5 (18–95)
Sex (*n* = 1133)	
Male	343 (30.3%)
Female	790 (69.7%)
Attending usual provider (*n* = 1131)	1077 (95.2%)
Years attending practice, mean ± SD; median (range)	10.4 ± 11.3; 6.0 (0–73)
Frequency of attending practice (*n* = 1118)	
Fortnightly or more	104 (9.3%)
Monthly	182 (16.3%)
Several times a year	679 (60.7%)
Yearly or less	153 (13.7%)
Size of practice attended (*n* = 1138)	
⩽ 2.0 FTE GPs	87 (7.6%)
2.1–5.9 FTE GPs	745 (65.5%)
⩾ 6.0 FTE GPs	306 (26.9%)
Location of practice attended (*n* = 1138)	
Major city (RA 1)	565 (49.6%)
Inner regional (RA 2)	573 (50.4%)
Attended accredited OST-prescribing practice (*n* = 1138)	
Yes	645 (56.7%)
No	493 (43.3%)

RA = Remoteness Area.[13] OST = opioid substitution therapy. * Figures are number of practices and number (%) of patients unless otherwise indicated. † Denominators vary for patient variables as not all respondents answered all questions. ◆

Statistical analysis

Associations were calculated using χ^2 analysis. Dichotomous outcomes were modelled using a logistic regression model within a generalised estimating equations framework to adjust for clustering of patients within practices. All analyses were performed using SAS version 9.2 (SAS Institute, Cary, NC, USA) and SPSS for Windows, version 17 (SPSS Inc, Chicago, Ill, USA).

As there is no previous research to suggest likely proportions of patients holding these attitudes, we adopted a conservative estimate of 50% for our power calculation. A significance level of 0.05 and a clinically significant difference of 10% were specified, with a power of 0.8. This indicated we needed 387 patient responses from each of inner regional and major city practices (and 387 patients from each of OST-prescribing and non-OST-prescribing practices). Assuming a response rate of 80%, we needed to invite 484 patients in each of inner regional and major city practices and each of OST-prescribing and non-OST-prescribing practices.

Results

Data were collected by 15 of the 16 practices, with about half including one to two OST prescribers (Box 1). From 1449 patients invited to participate, we received 1138 responses (response rate, 78.5%), with almost all respondents attending their usual practice (95.2%; 95% CI, 94.0%–96.5%).

Disturbing or unsettling waiting room experiences

A disturbing or unsettling experience in any general practice WR at any time was described by 18.0% of respondents (203/1130). The most frequent factor

2 Predictors of discomfort about sharing a waiting room with patients being treated for drug addiction

Variable	Univariate model		Final model	
	OR (95% CI)	*P*	OR (95% CI)	*P*
Sex				
Female	1.00		1.00	
Male	1.04 (0.86–1.25)	0.67	1.07 (0.88–1.31)	0.49
Location				
Major city (RA 1)	1.00		1.00	
Inner regional (RA 2)	0.97 (0.72–1.31)	0.85	1.02 (0.78–1.32)	0.90
Frequency of attending practice				
Fortnightly or more	1.00		1.00	
Monthly	1.20 (0.69–2.08)	0.51	1.15 (0.66–2.01)	0.62
Several times a year	1.46 (1.17–1.83)	< 0.001	1.52 (1.20–1.93)	< 0.001
Yearly or less	1.25 (0.84–1.86)	0.26	1.26 (0.84–1.88)	0.26
Negative waiting room experience where drug intoxication was a contributing factor*	1.12 (0.58–2.18)	0.73	1.32 (0.68–2.56)	0.41
Personal or family history of drug addiction*	0.87 (0.59–1.27)	0.46	0.85 (0.54–1.32)	0.46
Attending OST-prescribing practice*	1.23 (0.94–1.60)	0.13	1.27 (0.94–1.71)	0.12
Age (years)†	1.00 (0.99–1.01)	0.84	1.00 (0.99–1.01)	0.66
SEIFA Index†	1.00 (1.00–1.00)	0.93	1.00 (1.00–1.00)	0.60

OR = odds ratio. RA = Remoteness Area.[13] OST = opioid substitution therapy. SEIFA Index = Socio-economic Indexes for Areas Index of Relative Socio-economic Disadvantage.[14] * OR for "yes" answer (referent is "no" answer). † OR for a unit increase in the predictor variable. ◆

that respondents thought contributed to this was "poor parental supervision of a child", reported by 11.1% (95% CI, 9.3%–12.9%; 125/1128). Drug intoxication was an infrequent contributing factor, reported by 3.1% of respondents (95% CI, 2.2%–4.3%; 35/1128).

Discomfort about sharing a waiting room

More than a third of respondents (39.3%; 95% CI, 36.4%–42.2%; 424/1080) indicated they would feel uncomfortable sharing a WR with someone being treated for drug addiction. This was not significantly associated either with having had a negative WR experience where drug intoxication was a factor, or with attending an OST-prescribing practice (Box 2). It was significantly associated only with practice attendance of several times per year. Compared with sharing a WR with patients being treated for drug addiction, sharing with patients being treated for each of the other conditions was less likely to cause discomfort: for example, 12.2% (95% CI, 10.3%–14.2%; 130/1064) for a patient with severe depression or anxiety, and 27.9% (95% CI, 25.3%–30.6%; 299/1070) for a patient with difficulty with bowel control.

Intention to change practice

Most respondents (92.9%; 1038/1117) reported they would be very unlikely to, or would never, change doctors due to the behaviour or appearance of other patients in the WR.

Respondents were generally unaware of the OST-prescribing status of the practice they attended. Only 12.1% of patients attending OST-prescribing practices (70/579) correctly identified this characteristic, while 10.0% of patients from non-OST-prescribing practices (46/458) reported that the practice was OST-prescribing.

Only 15.9% of respondents (165/1037) reported being likely to change practices if theirs provided specialised care for opiate-addicted patients. To further assess the likelihood of changing practice if OST were provided, we excluded the views of the 70 respondents who correctly reported that their practice already provided OST prescribing. Of the remaining respondents who apparently believed they were attending a non-OST-prescribing practice, 17.1% (95% CI, 13.7%–18.1%; 165/967) reported that they would change practices if a GP at the practice provided specialised care for opiate-addicted patients. To place this in context, 28.7% (95% CI, 26.0%–31.4%; 302/1053) reported that they would be likely to change practices if they were consistently kept waiting for more than 30 minutes, and 26.6% (95% CI, 23.9%–29.3%; 275/1033) would likely do so if the consultation fee increased by $10.

In the regression model (Box 3), reported intention to change practice in the event of the practice providing care for opiate-addicted patients was predicted by neither previous drug-related unsettling WR experience nor

3 Predictors of patients changing general practices if the practice provided specialised care for patients with opiate addiction

Variable	Univariate model		Final model	
	OR (95% CI)	*P*	OR (95% CI)	*P*
Sex				
Female	1.00		1.00	
Male	1.46 (1.06–2.01)	0.02	1.23 (0.86–1.76)	0.25
Location				
Major city (RA 1)	1.00		1.00	
Inner regional (RA 2)	0.96 (0.66–1.39)	0.81	0.95 (0.71–1.28)	0.74
Frequency of attending practice				
Fortnightly or more	1.00		1.00	
Monthly	0.98 (0.57–1.69)	0.95	1.03 (0.53–2.00)	0.93
Several times a year	0.74 (0.40–1.37)	0.33	0.83 (0.45–1.53)	0.55
Yearly or less	1.02 (0.60–1.75)	0.93	1.21 (0.72–2.03)	0.48
Negative waiting room experience where drug intoxication was a contributing factor*	0.86 (0.41–1.81)	0.70	0.71 (0.37–1.35)	0.29
If consistently kept waiting more than 30 min*	2.18 (1.44–3.30)	< 0.001	1.90 (1.24–2.90)	0.003
If consultation fee raised by $10*	2.16 (1.61–2.90)	< 0.001	1.58 (1.07–2.33)	0.02
Personal or family history of drug addiction*	0.76 (0.50–1.17)	0.22	0.77 (0.49–1.23)	0.28
Attending OST-prescribing practice*	1.19 (0.84–1.67)	0.33	1.05 (0.75–1.48)	0.78
Age (years)†	1.01 (1.00–1.02)	0.003	1.02 (1.01–1.02)	< 0.001
Practice attendance (years)†	0.98 (0.96–1.00)	0.11	0.98 (0.95–1.01)	0.12
SEIFA Index†	1.00 (0.99–1.00)	0.33	1.00 (1.00–1.00)	0.71

OR = odds ratio. RA = Remoteness Area.[13] OST = opioid substitution therapy. SEIFA Index = Socio-economic Indexes for Areas Index of Relative Socio-economic Disadvantage.[14] * OR for "yes" answer (referent is "no" answer). † OR for a unit increase in the predictor variable. ◆

the OST-prescribing status of the respondent's practice. However, waiting time of more than 30 minutes and a fee increase of $10 were significant independent variables in this model.

Appropriate treatment location of patients with drug addiction

When asked where they thought someone (a hypothetical neighbour) with drug addiction should be treated, only 21.8% of respondents thought that general practice was an appropriate location, with 63.5% nominating a stand-alone clinic away from hospital or general practice (Box 4). There was a significant association ($P < 0.001$) between patients who would feel uncomfortable sharing a WR with patients being treated for drug addiction and the opinion that patients should not be treated for drug addiction in general practice.

4 Patients' perceptions of where patients with drug addiction should be treated (n = 1072)

Location of treatment*	Number (%; 95% CI)
General practice	234 (21.8%; 19.4%–24.3%)
Hospital clinic or outpatients	337 (31.4%; 28.7%–34.2%)
Stand-alone specialty clinic	681 (63.5%; 60.7%–66.4%)
Community pharmacy	37 (3.5%; 2.4%–4.5%)
Should not receive any treatment	12 (1.1%; 0.5%–1.8%)

* More than one response was permitted. ◆

Discussion

Our study demonstrates an apparent basis to GPs' concerns that patients would feel uncomfortable sharing their WR with patients whom they knew were being treated for drug addiction. Also, a sizeable minority (15.9%) expressed an opinion that they would change practices if their practice provided specialised care for opiate-addicted patients. However, discomfort in sharing the WR with patients being treated for drug addiction did not appear to be based on personal experience of drug intoxication in WRs and may thus represent stigmatising attitudes to patients with drug addiction problems.

The accuracy of respondents' assessments of whether their general practice already provided specialised care for patients with opiate addiction was surprisingly poor. Together with the finding that patients were considerably more likely to anticipate changing practices if they were consistently kept waiting more than 30 minutes or the consultation fee increased by $10 (both not infrequent scenarios in general practice), these results suggest that GPs' fears of losing patient patronage if they commence OST prescribing are unfounded, and should reassure GPs who are considering prescribing OST.

A strength of our study is that it is the first to quantify the opinions of patients regarding OST in general practice. It sampled patients from a range of practice demographics and from practices with and without OST-prescribing GPs, and achieved a high response rate.

A limitation is that our study only elicited expressed intention to change practices rather than actual change. To assess the actual numbers of patients changing practices after the commencement of OST prescribing would be problematic, as over 70% of GPs do not commence prescribing within the first year after training and authorisation.[5]

A further limitation is that our study was conducted in a network of research general practices rather than a random sample of practices. However, the demographics of the participating practices are broadly comparable with national samples, except that they are larger, service lower socioeconomic status areas, and have fewer major city practices and more inner regional practices.[15] Further, higher response rates of research network practices compared with randomly sampled practices may limit any bias.[16]

It is important for doctors and policymakers to recognise and respond to the impact of stigma in general practice. Stigma may make patients more vigilant and stressed, further impairing their social interactions.[17] Patients with opioid dependence, and their families, seek normalisation, and they depend on doctors to offer OST, not judgement. This study should allay some concerns of GPs regarding OST prescribing. Reducing the barriers to prescribing OST in general practice will minimise the individual and societal harm resulting from opioid dependence and improve compliance with UN calls to make OST more accessible.[1]

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