PRACTICE OBSERVED

Practice Research

Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: views on treatment

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Abstract

An important component of government policy on services for drug misusers is to encourage general practitioners to take a more active role. There are, however, some indications that general practitioners regard drug misusers as undesirable patients, although no evidence is available.

As part of a wider investigation of the role of general practitioners in the treatment of opiate misuse, a questionnaire, which was sent in mid-1985 to a 5% random sample of general practitioners in England and Wales, included a section designed to elicit their views on policy and treatment connected with opiate misuse. The results showed that although most general practitioners consider opiate misuse to be a priority concern for the Health Service, they also generally regard opiate misusers as especially difficult to manage, beyond their competence to treat, and less acceptable as patients than others in need of care. General practitioners who have qualified recently were somewhat less unfavourable in their views. These findings suggest that the effective implementation of government policy will require trying to modify general practitioners' attitudes and providing support for them.

Introduction

Encouraging general practitioners "to play a major part in the care and treatment of drug misusers" is a main concern in formulating health policy.[1] This was one of the purposes behind the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, issued by the Department of Health and Social Security in 1984.[2] This policy has received support from the House of Commons Social Services Committee in its report on *Misuse of Drugs*, which recommends that family practitioner committees "regard as a priority the encouragement of general practitioner services to drug misusers."[3] The DHSS has, indeed, recently drawn the attention of family practitioner committees to this in a circular.[4]

Though the Social Services Committee recognised the importance of the general practitioner's role, some of the evidence it received strongly indicates the problems of implementing their recommendation—and DHSS policy. For example, in a memorandum to the Social Services Committee the Royal College of General Practitioners said that it is prepared to "reaffirm strongly" the advice given in the *Guidelines*, but the college's verbal evidence is not encouraging. For one thing, it is suggested that many general practitioners are reluctant to take on addicts as patients because "they are a nuisance, they make demands . . . are abusive to the staff . . . a lot of general practitioners do not want to have anything to do with addicts."[5] Furthermore, it is pointed out that a general practitioner's training is insufficient to deal with addicts' devious methods of obtaining drugs.[6] A similar picture of general practitioners' attitudes emerged in a recent House of Lords debate, when the "typical" general practitioner was described as regarding addiction as a "self inflicted wound," unworthy of the doctor's valuable time.[7]

The receptiveness of general practitioners to the policy of promoting a more active role for them in the treatment of drug misusers is uncertain. Evidence pertinent to this question is largely anecdotal. The research findings reported in this paper provide a picture of the pattern of general practitioners' views and thus a firmer basis for assessing the viability of this policy.

Methods

Details of the methods were given in a previous paper[8] and are summarised here. A postal questionnaire was sent in mid-1985 to a 5% random sample of general practitioners in England and Wales, which was stratified by regional health authority. The final response rate, after three further waves of questionnaires had been sent as reminders, was 72% (n = 845). The respondents resemble general practitioners nationally in terms of the average number of patients on their lists and the number of partners.

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Two previous papers reported on responses to the sections of the questionnaire concerning the extent of contact general practitioners have with opiate misusers and actions taken in dealing with these patients.[8]

The third section of the questionnaire was designed to elicit the views of general practitioners on a range of issues on policy and treatment connected with opiate misuse. Ten "position statements" on these issues were presented, and on a five point scale the respondents could register the strength of their agreement or disagreement or indicate uncertainty in respect of each statement.

Results

The table gives the overall results from this section of the questionnaire. No correlations were found between when the questionnaire was returned—that is, whether in the first, second, third, or fourth response waves—and the views expressed; and hence no correction has been made for non-response bias.[9] Clearly, general practitioners overwhelmingly support the policy of the Department of Health of granting highest priority to developing services for drug misusers (statement 1):[4] 87% of respondents endorsing this view and 44% strongly agreeing.

To what extent, however, are general practitioners likely to respond to the call for improved services for drug misusers? They appear to be reluctant to accept opiate misusers as patients less than a third agree that they are prepared to take on opiate misusers as willingly as other types of patients (statement 7). Some possible reasons for this reluctance emerge in the responses to two other statements. Firstly, three quarters of the general practitioners agree that opiate misusers are more difficult to manage than other types of patients; more than a third (37%) strongly agree (statement 2). Also, almost two thirds regard the treatment required by opiate misusers as beyond the competence of general practitioners, with less than a quarter (23%) disagreeing (statement 8). This last finding may be compared with a similar item in a survey on managing alcohol problems in general practice where 44% of general practitioners felt capable of working with drinkers.[9]

This view of the limitations of general practice as the place to treat opiate misuse may reflect what the Royal College of General Practitioners has called "the special and complex needs of those addicted to hard drugs" and the insufficiency, as it claims, of a general practitioner's training for responding to those needs.[1] Part of the resistance of general practitioners to treating opiate misusers may lie in their understanding of the nature of the problem. Two thirds of the general practitioners endorse the view that opiate misuse is a symptom of underlying personality disorder (statement 10). Perhaps it is in this type of disorder that general practitioners believe lay difficulties in management and treatment.

General practitioners are certainly not entirely averse to treating opiate misusers. Most of the respondents agree that even when opiate misusers are not prepared to come off their drugs there is still a positive role for the general practitioner (statement 3).[1] The *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* were issued to enhance the confidence of general practitioners in treating these patients.[2] The guidelines may not have been circulated widely or there may not have been time to respond to the recommendations, for nearly one half of the general practitioners (44%) are uncertain on this issue, among the remainder who expressed a view, almost all agree that the guidelines provide the basis for a more confident role (statement 5).

On the grounds that it would discourage general practitioners from treating opiate misusers the government has now rejected a recommendation of the Medical Working Group, who produced the guidelines, to extend the current licensing arrangements for prescribing heroin and Diconal and cocaine to all opiate drugs except liquid methadone.[4] From this survey it appears that general practitioners are evenly divided in their judgment of whether or not the effect of such a measure would be to diminish their capacity to treat opiate misusers, a little more than one third agreeing and one third disagreeing with this suggestion (statement 6). Furthermore, there is a significant difference between general practitioners who reported elsewhere in the questionnaire that they had prescribed opiates to the patient whom they had most recently attended for opiate misuse and general practitioners who had not prescribed: 49% of the prescribers agree that extending licensing would diminish their capacity to treate opiate misusers (statement 6) compared with 28% of non-prescribers ($\chi^2 = 17{\cdot}65$; 2 df; $p<0{\cdot}001$).

Also, among the actions that many general practitioners had reported having taken while dealing with the opiate misuser who had most recently consulted was to refer the patient to a specialist drug dependence clinic. How satisfied are general practitioners in general with the response of drug dependence clinics?[2] Almost half of all respondents (44%) were unable to state a view, whereas a similar number (42%) express a positive view (statement 4). Among general practitioners who reported having made such a referral, 59% agree that clinics provide a responsive service and 22% are uncertain, compared with 36% agreeing and 41% uncertain among those who did not make such a referral ($\chi^2 = 21{\cdot}02$; 2 df; $p<0{\cdot}0001$). The findings also indicate that if back up resources were more widely available some general practitioners would be encouraged to take a more active role in the treatment of opiate misusers, 45% of respondents agreeing (statement 9).

This overall picture of general practitioners' views concerning opiate misusers is not particularly comforting for policy makers. There may be grounds for limited optimism in the results showing an association between the past and present of views expressed and how recently the general practitioner had qualified. In the questionnaire the general practitioners were asked to supply their year of qualification and, using this information, they were classified into three groups: those who qualified before 1960 (n = 278), those who qualified in the 1960s (n = 235), and those who qualified in the 1970s or 1980s (n = 293), with 39 respondents having missing data. No differences were found between the groups qualifying before 1960 and during the 1960s, but significant differences were found between the most recently qualified general practitioners and the others in their responses on several position statements.

Though only a quarter of general practitioners who qualified before 1970 agree that they are prepared to treat opiate misusers as willingly as any other patient in need of care, 40% of the general practitioners who qualified in the 1970s or 1980s agree ($\chi^2 = 18{\cdot}44$; 2 df; $p<0{\cdot}001$). Newer general practitioners also appear to be more confident of their ability to deal with drug misusers, as 49% of those qualifying in the 1970s and 1980s agree that opiate misusers require treatments that are beyond the competence of ordinary general practitioners, compared with 66% of other general practitioners ($\chi^2 = 21{\cdot}27$; 2 df; $p<0{\cdot}0001$). Again, the most recently qualified general practitioners take a less unfavourable view in their response to the statement that opiate misusers are likely to present more severe management problems than any other type of patient, with 67% of this group agreeing compared with 81% for the older general practitioners ($\chi^2 = 19{\cdot}99$; 2 df; $p<0{\cdot}001$). Finally the newer general practitioners would probably play a more active part in the treatment of opiate misusers if more back up resources were available; 54% of general practitioners who qualified in the 1970s or 1980s agree with this statement, while 39% of those who qualified before 1970 agree ($\chi^2 = 19{\cdot}27$; 2 df; $p<0{\cdot}001$). In numerical terms the variation between the recently qualified general practitioners and the others is not large and does not substantially modify the overall picture.

General practitioners' views on issues concerning opiate misuse (figures are numbers and percentages in parentheses)*

Position/statement	Agree or strongly agree	Uncertain	Disagree or strongly disagree	Total respondents	Missing cases (excluded)
(1) The Department of Health is correct in recently requesting health authorities to place the improvement of services for drug misusers in the category of highest priority	721 (87)	53 (6)	51 (6)	825 (100)	20
(2) Misusers of heroin/other opiate drugs are likely to present more severe management problems for the general practitioner than any other type of patient	633 (76)	111 (13)	85 (10)	829 (100)	16
(3) Even when misusers of heroin/other opiate drugs are not prepared to come off their drugs the general practitioner still has a positive part to play in their treatment	456 (55)	207 (25)	164 (20)	827 (100)	18
(4) In my experience, hospital drug dependence clinics provide a responsive service when referrals of heroin/opiate drug misusers are made to them	325 (42)	342 (44)	114 (14)	781 (100)	64
(5) The recent DHSS *Guidelines of Good Clinical Practice* provide me with the basis for a more confident role in the treatment of heroin/other opiate drug misusers	397 (49)	326 (41)	79 (10)	802 (100)	44
(6) My capacity to treat heroin/other opiate drugs misusers would be appreciably diminished if the prescribing of all opiate drugs was restricted (as with heroin and cocaine) to specially licensed doctors	281 (34)	240 (29)	294 (36)	815 (100)	30
(7) I am prepared to undertake the treatment of heroin/other opiate drug misusers as willingly as any other type of patient in need of care	253 (31)	164 (20)	400 (49)	817 (100)	28
(8) Misusers of heroin/other opiate drugs require forms of therapy beyond the competence of the ordinary general practitioner	491 (60)	137 (17)	190 (23)	818 (100)	24
(9) I would play a more active part in the treatment of heroin/other opiate misusers if more back up resources were available to me	364 (45)	260 (32)	190 (23)	814 (100)	31
(10) Heroin/other opiate drug misuse tends to be a symptom of underlying personality disorder	525 (64)	188 (23)	109 (13)	822 (100)	23

* Five point scale has been collapsed into three point scale.

Discussion

These findings suggest that the policy of promoting the treatment of drug misusers by general practitioners may be difficult to implement: most general practitioners regard opiate misusers as especially difficult to manage and beyond their competence to treat, and most are relatively unwilling to accept them as patients. This must be of concern to those who are interested in improving services for drug misusers. It is therefore not surprising that both the Medical Working Group and the Minister of State at the time with responsibility for policy felt the need to emphasise that general practitioners have a responsibility and "duty" to provide services to this group of patients.[2,4] The irony of this exhortation will not be lost on those who are aware of the policy implemented about 20 years ago, which specifically aimed at excluding general practitioners from this role.

The government has now rejected the "carrot" option, suggested by the Social Services Committee, of making additional payment to general practitioners who undertake special training and treat drug misusers.[4] Since general practitioners are independent contractors to the Health Service, working largely outside the planning system, there is little "stick" that can be deployed to steer general practitioners in line with central strategy.

The level of management of opiate misusers which may legitimately be expected of general practitioners is open to debate. Providing basic medical care for complications associated with drug misuse may be a more acceptable role for the general practitioner than prescribing opiates as maintenance treatment or even limited prescribing to help with withdrawal from drugs. The incentive, however, for general practitioners to undertake a more active role will be found in the establishment of a network of support, which was recommended by both the Advisory Council on the Misuse of Drugs[11] and the Social Services Committee.[3] These recommendations included close liaison with services in hospital and in the community (both statutory and non-statutory) and training opportunities that focus on managing drug misuse or the problems of dependence generally. At the same time the view of drug misusers that general practitioners have might be addressed by a campaign that would challenge certain global assumptions about drug misusers, identify measures that might be taken, and provide information on the range of local and national resources available to the general practitioner in responding to the needs of the drug misuser. Within such a framework the potential benefits of accessibility and early intervention offered by general practitioner services may be realised.

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This is the final paper of three.

Childhood gastroenteritis: a population study

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Abstract

A prospective study of gastroenteritis based on a population was carried out for 12 months on over 7000 children in general practice. The incidence of gastroenteritis was highest in the first year (127·7 children affected per 1000) and second year (90·8) of life, and gastroenteritis was rare after six years of age. Children from urban areas had gastroenteritis more commonly than children from semirural areas. A potential pathogen was isolated from half of the specimens: 78% were viruses, and rotavirus was identified most often.

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Introduction

Gastroenteritis is a major cause of childhood mortality and morbidity worldwide. Large studies have been carried out of children who were admitted to hospital with gastroenteritus, but little is known about the occurrence of gastroenteritis in the community in the United Kingdom.[1,2]

This study in general practice was undertaken to identify the agents that cause childhood gastroenteritis. Because the practices keep detailed records on all children it was possible to determine the age related incidence also.

Methods

The study period was one year, from 1 December 1984 to 30 November 1985. Five general practices in Oxfordshire, two urban and three semirural practices, were enrolled. Stool specimens were obtained when possible from children up to 14 years of age who presented to the general practitioner or health visitor with diarrhoea with or without vomiting. The specimens were sent to the Public Health Laboratory within 48 hours and were examined for parasites by formol ether concentration and by modified Ziehl-Neelsen stain for cryptosporidium,[3] by electron microscopy after concentration using ultracentrifugation for virus particles, cultured routinely for bacteria, and cultured for viruses and *Clostridium difficile* toxin on HEp-2, baboon kidney cells, and human embryo fibroblasts. Adenoviruses were identified by electron microscopy and not serotyped. A card with a brief questionnaire on the nature and duration of symptoms accompanied each specimen.

Hospital records were examined for all admissions of children with gastroenteritis during the study period, and children from the study practices were noted. Details of the age distribution of the children in the practices at the start and end of the study were obtained from the Oxford Community Health Project.

Results

There were 154 episodes of gastroenteritis during the study period, from which 143 specimens were obtained. Six children had two episodes each of gastroenteritis. There were six hospital admissions from the practices participating in the study.

Table I gives the incidence by age. The study population was taken as the mean of the number of children in each age group at the start and at the end of the study. The incidence was highest in the first two years of life and declined rapidly after 6 years of age. There was a small peak at school entry (5 to 6 years) and a possible secondary peak after 13 years. The annual incidence from the two urban practices was 40·7 and 35·6 episodes per 1000 children and from the semirural practices 26·5, 19·2, and 11·1 episodes ($\chi^2 = 24{\cdot}4$; 4 df; $p<0{\cdot}001$).

A potential stool pathogen was identified in 72 (50%) episodes, in four of which two pathogens were present (table II). Fifty nine (78%) of the 76 pathogens were viruses. Cryptosporidium was not detected. No clear clinical pattern emerged with different pathogens. Only two of 12 children with *Campylobacter* had bloody diarrhoea. Three children with astroviruses in the stool presented with diarrhoea of 10 to 14 days' duration.

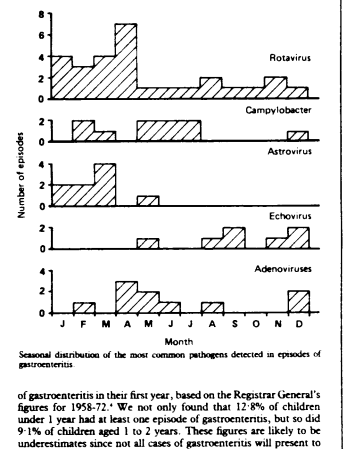
The figure shows the seasonal distribution of pathogens. Rotaviruses were most commonly detected in the late winter and early spring but were found every month. Astroviruses were also found mainly in the late winter.

TABLE I—*Incidence of childhood gastroenteritis by age. (Study population is mean of population at start and end of study)*

Age (years)	No of children with one or more episodes of gastroenteritis	Mean study population	Incidence (affected children per 1000 a year)
0-1	62	485·5	127·7
1-2	47	517·5	90·8
2-3	16	544·5	29·4
3-4	7	513	13·7
4-5	5	511	9·8
5-6	6	527·5	11·4
6-13	2	3371·5	0·6
13-14	3	565	5·3
Total	148	7033·5	21·0

TABLE II—*Pathogens (n = 76) isolated from 143 stool specimens from children with gastroenteritis*

Rotavirus	28
Campylobacter	12
Astrovirus	10
Adenoviruses	10
Echoviruses	7
Caliciovirus	2
Giardia	2
Clostridium difficile toxin	2
Bredavirus-like agent	1
Reovirus	1
Salmonella typhimurium	1



Seasonal distribution of the most common pathogens detected in episodes of gastroenteritis

Discussion

Surprisingly little is known about the incidence by age of childhood gastroenteritis in the United Kingdom. We were able to study this because of the cooperation of general practitioners who were enrolled in the Oxford Community Health Project and who kept detailed records of the age distribution of patients.

Tripp and Harries stated that 10% of children will have an episode of gastroenteritis in their first year, based on the Registrar General's figures for 1958-72.[4] We not only found that 12·8% of children under 1 year had at least one episode of gastroenteritis, but so did 9·1% of children aged 1 to 2 years. These figures are likely to be underestimates since not all cases of gastroenteritis will present to the health visitor or general practitioner. The incidence was higher in children from urban than from semirural areas.

The organisms that caused gastroenteritis in children at home were similar to those for which children were admitted to hospital.[1] Rotavirus was most frequently identified, with a peak in late winter and early spring but present throughout the year. Astrovirus infections occurred in the winter and sometimes with prolonged diarrhoea, as previously described.[5] Since the advent of electron microscopy diarrhoeal stools are rarely cultured for viruses. The results of this study show that tissue culture will yield several echovirus infections, occurring mainly in the autumn and early winter. Although adenoviruses were not serotyped, they were easily seen on electron microscopy and were presumably enteric adenoviruses. A virus that is structurally identical to Bredavirus was identified in the stools of one child.[6]

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