FOR DEBATE

General practitioners and opiate-abusing patients

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SUMMARY. General practitioners' involvement with patients who abuse opiates has increased in recent years but little is known about the difficulties they may encounter in working with such patients. This study examined a series of general practitioner consultations with patients who were abusing heroin and describes the problems that arose. Manipulative behaviour, lying about symptoms and a lack of motivation to give up drug use were common among drug abusers; by such behaviour, the patients failed to satisfy the underlying assumptions on which the doctor–patient relationship ordinarily depends. There is a need to evolve alternative approaches for the care of this group of patients which will help general practitioners to establish more effective relationships with them.

Introduction

OVER the past decade, the number of individuals abusing drugs such as heroin has increased substantially and this has necessitated a reassessment of policies for their management. The earlier view that drug abuse should be managed in centres established for this purpose has been replaced by a policy which places greater emphasis on the role of the general practitioner.[1] It has been similarly proposed that general practitioners should play an important part in the management of patients infected with human immunodeficiency virus (HIV)[2,3] and there are high rates of HIV infection among intravenous drug abusers who share needles.[4] The problem is not small; a recent survey in England and Wales[5] estimated that in a four-week period there would be approximately 9500 consultations with opiate-abusing patients, involving a fifth of general practitioners. Intravenous drug abuse was associated with 60% of known HIV carriers in Scotland in 1987.[6]

Because the contemporary pattern of opiate abuse is not entirely one of pharmacological dependence,[7] there appear to be good reasons for proposing that general practitioners are well placed to manage such patients. General practitioners' knowledge of the patient's circumstances, their relationship with the patient's family and their ability to treat other medical problems provide a desirable context for the management of drug abuse. Arguments of this kind have led to present policy but there has been little empirical enquiry into the care that general practitioners are able to provide or the problems they might encounter in doing so.[8,9] This paper reports a study of a series of consultations with drug-abusing patients and of general practitioners' experiences during these consultations.

Method

Direct observation or tape recording of consultations with opiate-abusing patients was not possible for practical and ethical reasons. Instead the participating general practitioners were given a semi-structured questionnaire which asked about the reasons for the consultation, its content and its outcome. Each doctor was asked to complete the questionnaire for two or three consultations with patients that they knew or suspected to be abusing heroin, as soon as possible after the consultation. They were encouraged to describe the encounter as fully as possible and to include their own feelings and attitudes. The questionnaires were then used as the basis for a tape-recorded interview with each doctor in which their initial responses were explored more fully.

Twenty-three general practitioners, working in five Glasgow health centres, participated in the study; all were from training practices. The sample was chosen on the basis of an expressed interest in the problem because it was felt that a small enquiry would be more useful if it focused on doctors who had experience of such patients and their management. In total, questionnaires were completed for 63 consultations; 50 were with 42 patients who were known to be using heroin at the time of the consultation. The analysis reported below is restricted to these 50 consultations.

Results

Details of patients and consultations

Of the 42 patients 24 were in the age range 20–24 years and a further 12 were aged 25–34 years; six were aged 15–19 years. Two-thirds of the sample were male.

A comparison between doctors' reports of the patients' presenting problems and their opinions about what they thought the patients actually wanted from them is shown in Table 1. A quarter of the consultations were initiated explicitly in an attempt to obtain drugs (not heroin) and a further third concerned medical problems associated with drug taking — the largest single reason was a request for help with withdrawal. However, the doctors considered that 29 (58%) of the consultations were initiated in order to obtain further drugs and requests for help with withdrawal were often seen as a device for obtaining further supplies.

The doctors expressed a negative view of the likely outcome of the encounter for 32 of the 50 consultations, were neutral about two and were positive about only 16. Similarly they had a treatment plan in mind for only 16 of the consultations and they rated the chances of the patient complying with the plan as better than poor for only two. The doctors who expressed a positive attitude to the consultation were also the most definite about the conditions they imposed on their patients.

Table 1. The problems presented by patients at the 50 consultations and the doctors' views of the reasons for the consultation.

	Number (%) of consultations	
	Patients' presenting problem	Doctors' view of the reason for the consultation
Obtaining drugs	13 (*26*)	29 (*58*)
Medical problem related to drugs	19 (*38*)	10 (*20*)
Medical problem not related to drugs	10 (*20*)	3 (*6*)
Other reason	8 (*16*)	8 (*16*)

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Patients' behaviour

Many of the doctors reported that drug-abusing patients were manipulative in their relationships, that they were adept liars and that they were rarely motivated to give up their drug taking. All three features of the patients' behaviour appeared to provide the basis of the disillusionment that many doctors expressed. Attempts to manipulate the consultation took a variety of forms but were almost always directed towards the demand for more drugs.

> 'He came in and said, "I've got this terrible pain in my tummy. Can you let me have some more of those Temgesic?" So I said, "No. I told you last time I wouldn't prescribe any more and that if you were still getting stomach pains I'd arrange for you to see a specialist." But no; he wasn't interested. "Well, if you're not going to give me any of them, how about something to help me sleep?" So I said I'd offer him some paracetamol and he said, "No, they're no good". And so it goes on in this fashion ... him saying what he wants and me saying I'm not prepared to give him them. That's how it is.'

Negotiation is one of the main mechanisms by which consultations are accomplished and even allowing for the nature of the encounter one might have expected the doctors to be skilled in managing the situations that arose. However, they repeatedly described circumstances in which they felt that their role as a doctor was compromised. One aspect of the consultations which appeared to distinguish them from those with other kinds of manipulative patient was the suggestion that, by prescribing, the doctors could be drawn into the deviant practices of the drug users:

> 'I felt very uncomfortable. Partly because I thought she might start asking for certain things but partly because I thought she was placing me in the position of a drug dealer discussing merchandise.'

Many general practitioners in the study felt that the extent to which these patients lied was a major obstacle in their relationships with them. Commonly, the doctors recounted stories of having been duped into accepting symptoms in good faith and were resentful of this breach of trust. Others were more cynical about the stories the patients told:

> 'He came in last week, sat himself down and said that his uncle was taking him to the Isle of Wight tomorrow at 8.00 am for six months. That he was determined to kick the habit and could he have a 100 Temgesic to help him to do it ... as far as going away in the morning is concerned, you get a lot of that ... I'd say about a third actually go — for the others, its just their story.'

Some general practitioners compared these patients with other groups — notably alcoholics — but saw the drug abusers as presenting a different kind of problem:

> 'With alcoholics you play a numbers game. They say two bottles and you can guess three or four. With the addicts its totally different. You just never know with them.'

The doctors felt that truth was not so much a casualty of the way that consultations were manipulated but rather something that was lacking altogether. This constituted the major obstacle to the doctors in their work with these patients. The general practitioners did not need to be told the truth all the time but they did need to be told it enough of the time for them to get some grasp of the patients' circumstances. Heroin-abusing patients were seen to violate even this fairly minimal expectation.

Generally, the doctors thought that the patients were consulting in order to continue their drug abuse rather than to stop or reduce it:

> 'Its hard to think you're getting a cry from the heart when they're sitting there asking you for named drugs, the amount, dosages...'

This was an important issue for the doctors since they felt that it was only in the face of an honest commitment on the part of patients to give up or reduce their drug use that there was any possibility of establishing a constructive therapeutic relationship. This view was combined, however, with the recognition that the patients' motivation was mediated by the social and environmental circumstances in which they lived:

> 'I asked him what proportion of his friends he knew were using heroin and he said between 80 and 90%. Now that's a highly selective sample but what chance would you give him of giving up unless he left the area completely.'

Discussion

Policy makers have assumed that general practitioners, in their traditional role, can contribute to the medical care of drug-abusing patients and can assist them in overcoming their problem.[1] While we would not challenge this assumption directly, the results of this study suggest that the experienced doctors who took part were only partially able to help these patients and then with great difficulty.

The principal problem appeared to be the difficulties they encountered in 'managing' their relationships when ordinary expectations of patient behaviour could not be assumed. In classical accounts of the doctor–patient relationship[10,11] there are shared assumptions that the illness, or its resolution, is beyond the decision-making control of the individual, that the sick person considers the illness to be an undesirable state, and that he should cooperate with those whose concern is to help him to get better. The consultations with opiate abusers often failed to fit this description.

It is possible to extend the argument by suggesting that there is a range of conformity to assumed behaviour in which some patients are closer to an expected norm than others. While some of the doctors cited alcoholics as another group of patients with whom they experienced difficulty there was a consensus that consultations with alcoholics were easier and followed more usual conventions than those with patients who were abusing heroin.[12] One explanation might be that alcoholics accept the assumptions of the sick role sufficiently to allow the establishment of some kind of therapeutic relationship while opiate-abusing patients do not.

Many doctors found it difficult to distinguish between occasions when they were genuinely consulted for help in giving up drugs, occasions when the patient had another medical reason for consulting and those when the patient was consulting simply in order to obtain drugs. The consequence was not only that the reality of the patient's complaint could not be assumed but that ordinary social conventions were also at risk. Conflict over advice and prescription was a common outcome. In these circumstances, it is scarcely surprising that some doctors choose to withdraw their services.[13] A further danger is that of adopting a stereotype of opiate-user behaviour which could confuse the recognition of other kinds of problem.

In the light of these difficulties it becomes necessary to explore alternative approaches to patient management which allow doctors to act in constructive ways. The nature of an acceptable relationship between the doctor and the patient must be made more explicit than usual. It will be important, for example, to establish practice policies which constrain manipulative behaviour, and this might be done by restricting the individuals with whom a drug user can consult and the occasions on which he can do so. Practical reality suggests that therapeutic goals should be short term and more usefully focused on the health problems associated with drug abuse than on the abuse itself. Prescribing policies should be especially clear and should not give the impression that they are open to negotiation. It is relevant that the doctors in this study who expressed positive attitudes to their consultations were also those who were most

definite about the conditions they imposed on their patients.

The purpose of the strategy suggested here is to redefine the rules for a group of patients who are potentially exploitative. There is also a need for collective approaches in which the policies for the care of drug-abusing patients are agreed by groups of doctors over fairly large areas. If doctors respond to these patients individually then there will continue to be the potential for manipulation.

This paper concerns consultations. We have no information about the drug-taking histories of the patients or their longer term relationships with their doctors and little is known of the stage in the natural history of the problem when the general practitioner might most usefully become involved. Drug abuse is probably a self-limiting problem,[14] but it is one that is associated with serious long-term hazards to the health of the individual. For this reason alone, it is important to evolve strategies which maintain at least some continuity in the care of these patients.

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