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General Practitioners and Drug & Alcohol Specialists Experiences with the Barriers

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Abstract

Introduction: Substance use disorders (SUDs) have an impact on physicians' health and quality of life, as well as possibly on the care they provide. Despite the existence of efficient particular Physician Health Programs (PHPs), physicians with SUD frequently encounter obstacles when attempting to get professional assistance. Therefore, using a multi-perspective approach, we looked at the facilitators and barriers to physicians getting care for SUD. Methods: For two sub studies, a qualitative design was chosen. First, responses to two open-ended questionnaire items (regarding predicted barriers and facilitators) were examined. 1,685 general practitioners responded to this survey (47% response rate). These open-ended questions responses were inductively coded. Second, 21 semi-structured interviews with physician SUD patients, their partners, and PHP staff members were conducted (regarding experienced barriers and facilitators).

Keywords: General practitioners • Drug and alcohol • Barriers

Introduction

According to research from the USA, doctors are slightly more likely than the general population (13%) to use alcohol in a harmful way (15%). Hazardous alcohol and drug usage among physicians was pegged at 3% and 18–23%, respectively, in Europe. There are few statistics available on the prevalence of substance use disorders (SUDs) among doctors. SUDs can, however, seriously injure patients and may also make it difficult for doctors to work normally. As a result, physician SUD may have an impact on the standard of care and patient safety. According to studies, mistakes in diagnosis and medical procedures as well as poor patient communication may result in clinical practise [1].

Description

Denial or minimising of substance use problems in the context of SUD adds another obstacle to obtaining care. Embarrassment and worry about potential repercussions were found to be big barriers to getting help, while specific incidents, such as driving under the influence or testing positive for drugs, and supportive relationships were found to be key facilitators. Less than half of the included research detailed a sample of doctors, and all included studies only covered the perspective of health-care workers with SUD, not that of significant others. However, few European studies were included (more than two-thirds were from the USA). To learn more about the obstacles and enablers that physicians face while seeking treatment for SUD, two qualitative methodologies were utilised. First, two open-ended questions from an existing online cross-sectional survey concerning the obstacles and enablers that general physicians might face were used. Second, semi-structured interviews with doctor SUD-patients, close friends, and PHP staff members were conducted. The open-ended questions were used to examine potential obstacles and opportunities for physicians as a whole. Based on their individual experiences seeking care for SUD among physicians, the interviews were used to more thoroughly study specific barriers and facilitators among physician-patients, significant others, and PHP workers [2].

We employed closed-ended questions from an online cross-sectional survey on "Addiction in Physicians." In September 2016, the Royal Dutch Medical Association's (RDMA) physician panel received this questionnaire. A link to the online survey and an offer to participate were sent to each panellist in an email. They were notified in advance of the questionnaire's purpose, and they had the option of participating or not. The questionnaire was due back to the panellists in three weeks. They were given two reminders to complete the survey. Through the use of a web-based questionnaire platform, encrypted data were gathered. The panellists' encrypted demographic data was combined with the questionnaire data [3].

There were 33 statements about equal rights to alcohol addiction treatment, most of which focused on improving the treatment's availability, accessibility, acceptance, and quality. Strong consensus agreement was reached on the majority of these statements. The expert panel recommended that there is a need to increase access to alcohol addiction treatment, including the creation of a solid referral system that includes alcohol problem screening. The expert panel recommended teaching health volunteers how to spot issues with alcoholism. Additionally, there should be designated beds for those with alcohol addiction in co-morbidity treatment wards and alcohol addiction treatment clinics in every general hospital so that people can seek treatment for alcoholism wherever in the nation [4].

The findings of this study also imply that some people with mental health and/or substance use issues favour collaborative, interdisciplinary primary care models in which services to address physical health, mental health, substance use, and social determinants of health are provided under one roof, and that models of care that lack such integration may present barriers for these populations. This is in line with other studies, since a sizable number of reviews and meta-analyses have demonstrated the value of collaborative care in the management of depression. A review of high quality quasi-experimental research and randomised controlled trials also identified some support for the advantages of integrated care models on anxiety, attention deficit hyperactivity disorder, and at-risk alcohol consumption in addition to this strong evidence for depression [5].

However, primary health care funding must be taken into account in order to increase the accessibility of such kinds of care. Participants in this study who were clients or service providers made clear connections between the inability

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to find a family doctor and the complexity of the patients' needs as perceived by them, and service providers cited current funding models as a key factor in doctors' reluctance to accept these patients. Although capitation funding models may also be problematic, traditional fee-for-service models are not conducive to addressing the barriers described here. This is because primary care settings operating under capitated models may de-roster patients who use outside primary care and, in doing so, drop patients with greater health needs. Incentives, capitation models based on diagnosis, salaried models, and support for non-physician primary care are possible substitutes.

Conclusion

Numerous implications for health care research, practise, and policy can be drawn from the study's findings. As many of the study participants believed that the primary care providers they had consulted lacked understanding about mental health and/or substance use as well as had high levels of stigma about these concerns, our study first suggests implications for provider education. These results are in line with prior studies that have shown family physicians themselves feel under-trained in these areas. If this is the case for providers who received their education somewhere else as well, further investigation is called for. In that scenario, it will be necessary to give providers with the necessary education to close the gaps in order to deliver high-quality primary care to this group.

Acknowledgement

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Conflict of Interest

None.

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