Emergency department physician attitudes towards buprenorphine initiation in the ED

A qualitative study

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BACKGROUND

- **Emergency department (ED)** visits related to opioid use have dramatically risen since the introduction of synthetic opioids into the illegal drug market.[1,2]
- In the recent years, **opioid agonist treatment (OAT)** is an effective option for patients with **opioid use disorders (OUDs)** and can be administered by trained physicians alongside complementary interventions and referrals.[3,4]
- **Buprenorphine**, one type of OAT, can decrease withdrawal, craving, and opioid use in individuals with OUD.[5]

OBJECTIVE

To explore and describe the ED physician perspective on:

- Caring for patients with opioid use disorders in the ED
- Initiating buprenorphine/naloxone (Suboxone) in the ED
- Providing other interventions for patients with OUD in the ED

METHODS

- **Study Design:** Focused ethnography
- **Recruitment**: Purposive and snowball sampling techniques
  - *CRISM ED Buprenorphine Working Group:* Kathryn Dong, Aaron Orkin, Andrew Kestler, and Janusz Kaczorowski
  - National network of site leads (as identified by the Working Group) are provided study information to share with their roster of staff ED physicians
  - ED physicians who are interested in the study voluntarily contact the study research coordinator for more information and/or to schedule a one-hour interview
- **Compensation**: $50 Starbucks gift card
- **Data Analysis**: Inductive content analysis

ELIGIBILITY CRITERIA

- Actively working in an ED in Canada
- Practicing emergency medicine for at least one year
- Working an average of four shifts per month (or more) in the ED
- Did not previously participate in the study
- Not a resident physician

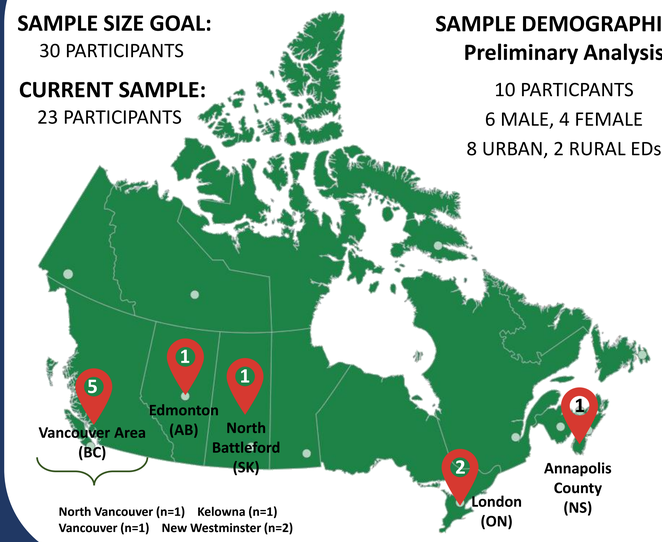
PARTICIPANTS

SAMPLE SIZE GOAL:
30 PARTICIPANTS

CURRENT SAMPLE:
23 PARTICIPANTS

SAMPLE DEMOGRAPHICS:
Preliminary Analysis

10 PARTICPANTS
6 MALE, 4 FEMALE
8 URBAN, 2 RURAL EDs



PRELIMINARY RESULTS

SCREENING PROCESS

There were mixed opinions regarding implementing an official screening protocol to identify patients with OUD in the ED.

"I think it's almost a little bit unfortunate because it seems like we're being asked in the emergency department to screen for everything…I don't mean to diminish any of these very important health care issues and social issues, its just that I have some reservations about the emergency department being everything to everyone." – **Participant #4 (ON)**

STIGMA

Almost all participants (so far) have acknowledged that stigma towards patients with OUDs is prevalent in the ED, primarily due to difficult situations they experienced in the past.

Stigma was also noted to influence the way services were provided to patients with OUDs, as well as how they were treated when in the ED.

"I think stigma is a huge problem. I think it's somewhat better since the opioid crisis has really come to light. I think that our healthcare teams are becoming more aware of [how] at risk these patients are and the challenges that they face. But there's still a lot of stigma regarding patients who have substance abuse disorder, certainly the term of the drug-seeker, is still used and with that statement implies you know, that this patient should just be discharged. That we shouldn't be providing them with analgesia and it's you know certainly a whole host of preconceived kind of notions when that term is used. And so, I think there certainly are still patients that avoid coming to the emergency department because of past experiences that they have that have been traumatizing." – **Participant #7 (BC)**

STARTING SUBOXONE

Most participants felt comfortable starting Suboxone in the ED if resources and supports were accessible.

"I feel comfortable with many presentations, although Suboxone initiation, I haven't done many…I find I still like to get advice from my addiction colleagues. For any Suboxone initiations I do, [I] will still talk to the consult team for advice, that's still something I don't feel comfortable doing completely on my own at this point." **– Participant #7 (BC)**

APPROPRIATE SETTING

There was poor consensus among participants regarding whether the ED was an appropriate environment for Suboxone initiation.

"I think physicians feel it's not within their scope, it's not their job, it's really the scope of the addictions doctors, not us. We really shouldn't be starting long term medications in the emergency department, on any medication, and it definitely qualifies as that." – **Participant #6 (BC)**

"I think that there's a lot more that we could do in the emergency community to help identify people at risk and offer them potentially very beneficial or life saving treatments like Suboxone" – **Participant #3 (BC)**

BARRERS TO STARTING SUBOXONE

- Lack of follow-up outpatient resources/clinics
- Inadequate time and space
- Reluctant or challenging patients
- Inadequate training
- Staff attitude
- Precipitated withdrawal (patient experience or fear of causing it)
- Patient's cognitive state

FACILITATORS TO STARTING SUBOXONE

- Additional education on ED Suboxone
- Multiple attempts at initiating Suboxone
- Educating patients on Suboxone
- Having an established referral process
- A safe space for patients to receive wraparound supports

NEXT STEPS

We will **continue interviewing ED physicians** across Canada and **finalize our qualitative analysis** to further our understanding on this topic.

TAKE HOME SUBOXONE

In general, participants favourably perceived Take Home Suboxone, despite having limited practical experience prescribing it

REFERENCES

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