

a tenable solution to the problem. The six hours provided did not necessarily reflect the choice of the speech and language therapists in the study but rather a constraint imposed on them by the “package of care” model of service delivery. The data suggest that such a simplistic model is not helpful and that the practitioners and their managers should be able to offer a more flexible package of interventions. This is likely to require a reorganisation of speech and language therapy services, but this is the point of practising evidence based medicine: when you fill the evidence gap you need to act.

James Law *reader*

Language and Communication Sciences, City University, London EC1V 0HB

Gina Conti-Ramsden *professor of child language and learning*

School of Education, University of Manchester, Manchester M13 9PL

- 1 Drillien C, Drummond M. *Developmental screening and the child with special needs*. London: Heinemann, 1983.
- 2 Reid J, Millar S, Tait L, Donaldson ML, Dean EC, Thomason GOB, et al. *The role of speech and language therapists in the education of pupils with special educational needs*. Edinburgh: Edinburgh Centre for Research in Child Development, 1996.
- 3 Bax M, Hart H, Jenkins S. *Child development and child health*. Oxford: Oxford University Press, 1990.
- 4 Johnson CJ, Beitchman JH, Young A, Escobar, M, Atkinson L, Wilson B, et al. Fourteen-year follow-up of children with and without speech/language impairments: speech/language stability and outcomes. *J Speech Lang Hear Res* 1999;42:744-60.
- 5 Stothard SE, Snowling MJ, Bishop DVM, Chipchase BB, Kaplan CA. Language-impaired preschoolers: a follow-up into adolescence. *J Speech Lang Hear Res* 1998;41:407-18.
- 6 Clegg J, Hollis C, Rutter M. Life sentence: what happens to children with developmental language disorders in later life? *Bull R Coll Speech Lang Therapists* 1999;57:1:16-8.
- 7 Howe MJA. *IQ in question: the truth about intelligence*. London: Sage, 1997.
- 8 Campbell FA, Ramey CT. Effects of early intervention on intellectual and academic achievement: a follow-up study of children from low-income families. *Child Dev* 1994;65:684-98.
- 9 Glogowska M, Roulstone S, Enderby P, Peters TJ. Randomised controlled trial of community based speech and language therapy for preschool children. *BMJ* 2000;321:923-6.
- 10 Law J, Boyle J, Harris F, Harkness A, Nye C. Screening for speech and language delay: a systematic review of the literature. *Health Technol Assess* 1998;2:1-184.

## The place of walk-in clinics in healthcare systems

*Uncertainty about impact demands careful evaluation and policy making*

Papers p 928

Walk-in clinics have existed in Canada since the late 1970s, but the evidence on who uses them and why, and their effectiveness and economic impact, is disconcertingly sparse. Of the nine primary studies cited in a review of walk-in clinics in Canada, published in this issue of the *BMJ* (p 928), six were surveys of patients attending walk-in clinics, emergency departments, or general practices; one was a review of the clinical records of patients attending an after hours clinic; one surveyed staff informants at walk-in clinics about organisational arrangements and services; and one compared the costs of treatment at walk-in clinics, general practices, and emergency departments using data on fee for service claims from a provincial health insurance plan.<sup>1</sup> All but two studies were based on a single walk-in or after hours clinic or on samples of patients drawn from one or a small number of general practices. Most studies provided data from the early 1990s or earlier and may not reflect current use.

The only economic evaluation that was identified concluded that the cost of care at walk-in clinics was similar to costs at general practices and that this was lower than costs at emergency departments.<sup>2</sup> Although this study has methodological limitations—including the potential misclassification of walk-in clinics, after hours clinics, and family practices; an unknown degree of diagnostic inaccuracy; and an inability to distinguish whether subsequent visits were for the same condition as the initial visit—the results are consistent with findings from the United States that costs are higher in emergency departments than in other primary care settings.<sup>3,4</sup>

There is a lack of evidence on the quality and effectiveness of the care provided in Canadian walk-in clinics as compared with other primary care settings; there

is also no evidence of their impact on the overall utilisation of primary care services and the costs of primary health care. A recent study comparing quality, utilisation, costs, and satisfaction with care at walk-in clinics, emergency departments, and general practices in the province of Ontario will partially fill this gap (unpublished data). The controlled trials register of the *Cochrane Library* includes no studies on the effectiveness or efficiency of walk-in clinics.

In the absence of evidence, advocates of walk-in clinics claim that the clinics save “millions of dollars” for provincial healthcare plans by reducing the number of visits that patients make to emergency rooms; critics of walk-in clinics accuse them of providing “fragmented, intermittent care” because they fail to attend to preventive care, chronic disease management, and psychosocial issues.<sup>5</sup>

Walk-in clinics developed in Canada not from the deliberate policy decisions of provincial ministries of health but in response to the entrepreneurial opportunities offered by the public funding of physician’s services through fee for service payments. Having played no part in their creation, ministries of health have remained on the sidelines, taking no policy initiatives to either discourage or encourage their proliferation.

In the absence of walk-in clinics the options available to the public are self care, care in an emergency department, or care by a general practitioner. People who decide to treat themselves or have to wait to be seen by a general practitioner may, along with their caregivers, experience varying degrees of worry. Theoretically, inappropriate self care or delayed care could cause morbidity that might have been avoided with timely treatment. Unfortunately, there is no evidence that the speedier access to care

*BMJ* 2000;321:909–10

afforded by walk-in clinics reduces subsequent morbidity.

Presumably, policymakers would not want to establish walk-in clinics as substitutes for appropriate self care or care by general practitioners unless they placed a high premium on reducing anxiety. If policymakers wanted to encourage self care, they might look to public education interventions as an alternative to walk-in clinics.

Policymakers may, however, wish to divert care for acute minor conditions from emergency departments to other primary care settings, possibly including walk-in clinics and general practices. Before doing so they should consider what arrangements need to be in place in all three settings to encourage this shift while ensuring that patients' needs and reasonable expectations are met. Options might include developing policies that make access to general practice services easier both during and outside regular consulting hours; they might also include telephone triage and advice services staffed by nurses. Telephone services could relieve anxiety for many patients who either are treating themselves or waiting to see a general practitioner, and these might also be add-on services for the "worried well."<sup>6-8</sup> What is needed, as in all

policy initiatives, are clearly specified objectives; consideration of the effects that might occur elsewhere in the healthcare system and beyond; anticipation of the potential responses of stakeholders (especially, in the case of walk-in clinics, patients and general practitioners); and preplanned, adequately funded, and rigorous evaluation of innovations.

Brian Hutchison *professor*

Departments of Family Medicine and Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, Ontario L8N 3Z5 (hutchb@fhs.mcmaster.ca)

- 1 Jones M. Walk-in primary medical care centres: lessons from Canada. *BMJ* 2000;321:928-31.
- 2 Weinkauff DJ, Kralj B. Medical service provision and costs: do walk in clinics differ from other primary care delivery settings? *Can Public Policy* 1998;24:471-84.
- 3 Baker LC, Baker LS. Excess cost of emergency department visits for non-urgent care. *Health Aff* 1994;13:162-71.
- 4 Warren BH, Isikoff SJ. Comparative costs of urgent care services in university-based clinical sites. *Arch Fam Med* 1993;2:523-8.
- 5 Priest L. Critics stomp on walk-in clinics. *Globe and Mail* 2000 January 28:A3.
- 6 Shekelle P, Roland M. Nurse-led telephone lines. *Lancet* 1999;354:88-9.
- 7 Teasdale C. Oh yes, it's popular; but is it effective? *Family Practice* 1999;11:11-3.
- 8 McCann W. Medical advice called growth industry and risk. *Hamilton Spectator* 1999 February 22:A10.

## The management of anal warts

*Topical self treatment, ablative therapy, and counselling should all be available*

The incidence of condylomata acuminata, commonly known as anogenital warts, is increasing. In the United Kingdom it is the most common sexually transmitted disease; in 1997 over 50 000 new cases were reported, accounting for 22% of all diagnoses made in genitourinary medicine clinics.<sup>1</sup> In the United States an estimated 1% of adults who are sexually active have lesions.<sup>2</sup> These benign warts are caused by human papillomavirus; genotypes 6 and 11 are found in over 90% of cases.<sup>3</sup> However, some patients are concurrently infected with oncogenic types of the virus, principally genotypes 16 and 18, which may induce multifocal anogenital intraepithelial neoplasia and cervical cancer.<sup>4</sup> Although people with anogenital warts present to many different disciplines guidelines for management have recently been published by the Medical Society for the Study of Venereal Diseases of the United Kingdom and the European Course on Human Papilloma Virus Associated Pathology Group.<sup>5, 6</sup>

These guidelines conform to recommendations as for a Cochrane review and focus on sharing management between specialists and primary care physicians.<sup>7</sup> No specific treatment and no one therapeutic recipe is appropriate for all patients. Although most modalities will achieve clearance of the virus within 1-6 months, in 20-30% of patients new lesions and relapses will occur over months or even years as a result of failures in specific immune recognition and cell mediated clearance.<sup>8</sup> This is a

highly frustrating experience for patients and caregivers.

There has been a shift in the focus of treatment towards topical self treatment for patients, using agents such as podophyllotoxin (0.5% solution or 0.15% cream) and imiquimod (5% cream). Clearance rates seem to be equivalent for the two drugs. In many patients imiquimod, which modifies the immune response, may induce the necessary cell mediated immune response for clearance, and it has a low relapse rate.<sup>9</sup> But imiquimod costs more than podophyllotoxin and takes longer to cure the condition. A study is needed to directly compare imiquimod with podophyllotoxin to address issues of comparative effectiveness, cost, and psychosexual advantages.

Podophyllin, 5-fluorouracil, and interferons are no longer recommended for use in primary care because of their low efficacy and toxicity.<sup>5, 6</sup> Podophyllin 20-25% is inexpensive, but it is mutagenic and only moderately efficacious.<sup>10</sup> Recommended treatments that can be used in the doctor's office include trichloroacetic acid or physical ablation using cryotherapy, electrosurgery, excision, or laser treatment.<sup>5, 6</sup>

Clinicians who treat anogenital warts need to be knowledgeable about and have available at least one treatment that can be used in their office and one that can be used in the patient's home. Choosing the right treatment for each patient depends on a combination of factors including the number of warts, the anatomical site, the morphology of the lesions, and the patient's

*BMJ* 2000;321:910-1