Health care just a phone call away

The Resources report by Dr Kahane et al[1] illustrated how physicians can access community services for their patients in the greater Toronto area with The Blue Book. Community Information Toronto is the producer of The Blue Book. They have also created a provincewide service directory, which is available to patients through Telehealth Ontario. Registered nurses with Telehealth Ontario can provide callers with telephone numbers for local services during discussions about their health concerns.

For example, callers can be given the numbers for new mothers' groups or meetings of the Alzheimer's Society, depending on their needs. Telehealth Ontario is a toll-free, bilingual, 24-hour-a-day service that patients can call directly. It enables patients to take advantage of services available to them locally.

—Sue MacLean, MD, CCFP
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by e-mail

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Volunteer clinic for the uninsured

Since its inception in May 2000, a non-profit Volunteer Health Clinic for the Uninsured has grown to meet the needs of its community. It is a partnership program between the community and the Department of Family Medicine and Community Services at the Scarborough Hospital in Ontario. Patients have access to medical assessments, medications, laboratories, and specialists. To date, approximately 2000 patients have been seen.

The clinic, however, provides more than just medical care. It offers an excellent teaching and learning environment for the family medicine residents training at the Scarborough Hospital through the Department of Family and Community Medicine at the University of Toronto.

Family medicine residents are sent to the clinic to work alongside community family physicians during their family medicine rotations. With limited resources, uncertain patient follow up, and a variety of community resources to choose from, residents work with public health nurses to meet the needs of patients. The clinic allows residents to identify key community resources for patients seeking shelter, food, child care, and medical care. Family medicine residents also have the opportunity to learn from one-on-one teaching from family physicians. Family medicine residents can be involved in managing patients who require obstetrical care in hospital by attending deliveries and providing postnatal care, thus allowing for continuity.

The four principles of family medicine outlined by the College of Family Physicians of Canada[1] identify that family medicine is community based, family physicians should be a resource to a defined population, family physicians should be skilled clinicians, and the doctor-patient relationship is central. The clinic provides family medicine residents with the opportunity to build on these principles. The role of family medicine residents at the clinic demonstrates the ongoing commitment to excellence in education by this community-based residency training program.

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Time to establish a successful model

In response to the articles[1,2] on primary care reform in the February issue of *Canadian Family Physician*, we would like to highlight another model.

By working with multidisciplinary teams in community-based and community board–directed centres, family physicians in Ontario community health centres (CHCs) have offered comprehensive health care that directly meets the needs of the community for almost 30 years. They provide the "basket of services" identified by both the Provinical Coordinating Committee on Community and Academic Health Science Relations and the Family Health Networks as appropriate for primary care sites. Within the CHC model, family physicians are encouraged to practise in a manner consistent with the four principles of family medicine. They are able to devote their time to fully using and expanding their range of clinical skills within the physician-patient relationship and to being a resource to a defined community.

Traditionally, CHCs are well placed to deal with high-needs patients with complex physical and mental health problems, as well as patients who experience barriers to accessing primary care. Health promotion, prevention, and care can be practised in a patient's environment through use of team models and a community outreach approach.

A range of primary care services, including housecalls, nursing home visits, and obstetrical services as well as expanded services, such as chiropody, counseling by social workers, nutrition counseling, and lactation support, can be offered by various team members. Physicians in CHCs also have the opportunity to participate in developing and implementing innovative programs to promote good-quality primary care (eg, the community diabetes education program).

This model works well for physicians, patients, and communities. Physicians are paid a salary with stipends for on-call and obstetric and hospital work and receive a full benefit package. Holiday and study leaves are paid. There is administrative support for finding locum tenens physicians. Physicians can work together in larger groups to ensure a range of clinical services and on-call coverage are available.

In this era, when new and established family practitioners are moving away from providing comprehensive cradle-to-grave care to a defined population, CHCs offer an attractive alternative. They also offer an alternative for patients who are increasingly frustrated by the fractionation of care inherent in the fee-for-service system. We suggest that it is time to look at an established and successful model.

—Dona Bowers, MD, CCFP, FCFP
—Alison Eyre, MD, CCFP
—Frances Kilbertus, MD, CCFP
—Laura Muldoon, MD, CCFP
Ottawa, Ont
by e-mail

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...

I am a little perturbed by Rosser and Kasperski's[1] apparent naïvety in regard to human (ie, doctor) nature and health care funding. They seem to assume that the very doctors who are moving into walk-in clinics because of the easier lifestyle and better remuneration will suddenly come running back to full-service general practice just because the payment model (but not necessarily the pay) is different.

Surely the simple way to entice these same people into making housecalls, hospital visits, and doing obstetrics and complex patient care is to adequately reward this type of work. I think most will agree that, if the fee for a housecall was dramatically increased, the market would respond by closing the walk-in clinics and having teams of doctors driving around (or even being driven) armed with their doctors' bags and cellular telephones. Surely this makes more practical sense than trying to change a whole system to one that is producing no better results (and certainly no better doctor morale) elsewhere.

—Paul Mackey, MBBS (MELB), DRANZCOG, DA (UK), CCFP, FRACGP
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I would like to express my grave concerns about the proposed expansion of family health networks in Ontario and of primary care reform in general.

The family health network model looks good in theory, but in reality it is a disturbing blueprint for large-scale reform. Its stated intention is to support doctors to provide comprehensive care in a manner that will be beneficial to patients and financially remunerative to family physicians. The success of this model, however, is based on the premise that most patients are relatively healthy and will not put too great a demand on their family doctors. But is this realistic in a population that statistically is aging and thus is characteristically going to be predominantly female, low on financial resources, and chronically ill?

As a family doctor working on the front lines of patient care, I am terrified by this model. I serve patients who are, by the nature of their health

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care needs, tremendously time-consuming. I see patients suffering from HIV disease, drug addiction, chronic illness, psychiatric problems. I see patients whom many doctors do not want to see. They would certainly not want to see my patients under the capitation model that the family health network espouses. I provide good and essential care. And I am not alone.

I spend the necessary time with each patient, and I see people as frequently as is necessary. This will not be rewarded under the proposed model. Because of the longer time that I spend with patients, I have a small practice. I could not possibly manage 2000 patients with high needs. The proposed family health network, while it does financially "nod" to the timely demands of comprehensive care, is helpful only in practices that have enough "easy" or healthy patients to balance out the more demanding ones. But my practice, as in many inner-city centres, does not come close to balancing out. Health policy research has shown repeatedly that low-income people have more chronic illnesses and as a result, require more health care services. Even with the financial incentive provided for more demanding patient loads, I would not be able to afford my private practice.

While I might find more reasonable compensation at a community health centre, my patients would have to find a family health network doctor who would be able to accommodate their greater needs. These patients would find, furthermore, that community health centres, which are principally oriented to serving complex patients, are too busy to accommodate more patients. Even now, before these changes take place, many community health centres are unable to take on new patients, except, for example, earmarked populations, such as the homeless.

The fee-for-service model could be reformed. I suggest that OHIP codes be updated to reflect time-consuming tasks, by increasing the number of codes that reflect time units. This is already in place: counseling, psychotherapy, HIV, and palliative care are all compensated by time taken, rather than service provided. Add housecalls, telephone calls, and care for the chronically ill and elderly to this list. Doctors can document the time taken (indeed, this is already an expectation). Policy makers can then be assured that potential abuse is curbed and cost ceilings are maintained, as there are only so many time units in a day.

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I suggest that community health centres be expanded, especially in the wake of these reform initiatives. I also have great political reservations about primary care reform. I worry that family health networks are yet another step toward privatization of health care. Family health networks represent the wide-scale introduction of managed health care in Ontario. It is not surprising that these networks meet with government approval, given receptive attitudes toward privatization and given that debates about user fees, private hospitals, and OHIP delisting that fosters a two-tiered system of services are currently encouraged. We need only look to Britain and to the United States to see the danger we are getting ourselves into.

—Vera Ingrid Tarman, MD
Toronto, Ont
by fax

Treating persistent cough: caution!

I read with interest the Practice Tip by Peleg and Binyamin[1] regarding treatment of persistent cough with lidocaine and bupivicaine. I have occasionally found inhalation lidocaine helpful in palliative management of cough related to intrathoracic disease. The potential loss of a gag reflex is noted as a side effect.

I would, however, disagree with their statement that no other adverse effects have been reported. McAlpine and Thomson[2] have noted that inhaled topical lidocaine causes bronchoconstriction in a notable proportion of asthmatic patients. Groeben et al[3] have suggested that, although both intravenous and inhaled lidocaine greatly attenuate reflex bronchoconstriction, there is a high incidence of initial bronchoconstriction after patients use inhaled lidocaine. They subsequently suggested the possibility of using lidocaine along with salbutamol to prevent the initial bronchoconstriction seen with lidocaine alone.[4]

Given that a chronic cough is commonly associated with undiagnosed or undertreated asthma, treatment with inhaled anesthetic agents could be dangerous and should likely be undertaken only in carefully selected circumstances.

—Cornelius Woelk, MD, CCFP
Winkler, Man
by e-mail

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What is the role of walk-in clinics?

The March 2002 issue of *Canadian Family Physician* focused on another timely topic: walk-in clinics. One result, however, was taken from the paper "Who provides walk-in services?"[1] by Barnsley et al and was highlighted three more times in the journal; in my opinion, such attention was not justified.

The result was that more than 60% of visits were made by "regular patients." This point was mentioned by Borkenhagen[2] in his editorial, by Reid[3] in Editor's notes ("This provides new evidence that walk-in clinics do more than 'skim off the cream' and fill an important role in primary care"), and in the Editor's key points[1] that accompanied Barnsley et al's paper.

First, in the article,[1] there is no definition of "regular." If patients with heart disease go to walk-in clinics for several blood pressure checks a year, but attend their own family doctors for referrals and follow up, are they "regulars" of the walk-in clinics?

Second, the result comes from a self-administered questionnaire, which was completed by either a physician or a staff member. There was no objective measurement to see whether there was over-reporting or whether patients had other family physicians, or whether they were "regulars" at several walk-in clinics. I would have liked to have seen the profiles of regular patients. Were they 23 and healthy or 65 and not? I do not think the objectively unsupported and undefined figure of 60% should have been given such prominence.

Traditional physicians in urban settings, like me, however, cannot complain about the proliferation of walk-in clinics. We have made it downright inconvenient to access our services. We are open only during working hours, patients have to make appointments, and often patients pay high fees to park. No wonder we attract only those who are unemployed or who have a problem serious enough to jump through all these hoops.

There are, however, models that will accommodate accessibility and continuity. Age- and disease-weighted capitation would be one model. Accessible physicians would attract more patients. One could add a proviso that a patient seeing another physician, eg, at a walk-in clinic, would have to pay for part of the visit; the remainder would be paid by the medical plan, who would deduct that amount from the physician who received the capitation payment. This would provide an incentive for capitation holders to make themselves available and provide a disincentive for patients to hop around or be a "regular" at several clinics.

—D. Behroozi, MB BS, LMCC, CCFP
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by e-mail

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In the March 2002 issue, Dr Rainer H. Borkenhagen wrote an editorial[1] on walk-in clinics. In it, he postulated reasons for the emergence of walk-in clinics and suggested that they are a natural progression of primary care in our society. He suggests as well that the differences between walk-in clinics and full family medicine practices are slight.

I believe that walk-in clinics exist for a solitary purpose: it is easier for physicians to make money in walk-in clinics than to set up and operate traditional medical practices. Facts support this assertion.

Walk-in clinic doctors in our city can see 50 patients in less than 4 hours. They do not have comprehensive files. They do not have 24-hour coverage. They do not have hospital privileges and therefore do not do obstetric or emergency care. They do not assist at surgery, and they do not follow up patients in the hospital. They do not attend to nursing home patients. They certainly do not sit on hospital committees, boards, or community panels. They are not involved in our hospice society. Most of the walk-in clinic doctors do not even live in our community.

In primary care, the money-maker for physicians is the office visit. The shorter the visit, the more financially rewarding it can be for physicians. Doing hospital rounds, assisting in surgery, delivering babies, and providing care at nursing homes are time-consuming and often do not generate nearly the same income per hour as walk-in clinic work. Hospital committee work is not reimbursed at all.

Walk-in clinic doctors in our community have short office visits and earn big bucks. I had one irate mother tell me about a visit to a local walk-in clinic with her sick child. The total encounter with this generic doc-in-the-box took 30 seconds, and the product of the visit was a prescription for amoxicillin. When the mother asked the doctor whether he was going to examine the sick child, the doctor said he was too busy to do such things and to check with her regular doctor if the child was not better soon.

The reason such nonsense exists in primary care delivery is that the provincial Medical Services Commissions do not look at obtaining proper value for the dollars they spend in primary care. If these commissions did look at this, they could influence family physicians

to have full-service practices instead of walk-in clinics.

Corrective action by Medical Services Commissions (ie, payers) could be rapidly taken to encourage physicians to operate as full-service physicians in large groups, providing comprehensive and timely care that is far more valuable to society than the band-aid approach offered by the numerous walk-in clinics that have sprouted up in our city. This is *not* rocket science.

It is the duty of the paying agent (acting on behalf of taxpayers who fund the system) to ensure health care providers and health care consumers act responsibly to get the most from each publicly funded dollar spent. In British Columbia, the Medical Services Commission will immediately put forth the rebuttal that the commission acts in concert with the BC Medical Association to pay physicians in this province and that the doctors help determine payment processes. While this is correct, the commission would probably not mention that the BC Medical Association is dominated by physicians who would own and operate walk-in clinics and would therefore have a vested interest in making decisions about these clinics. Beyond such an argument, the commission cannot shirk its fundamental duty to arrive at its own objective views on the use of its money.

If we continue in this fashion, there will soon be no family physicians in Canada and more walk-in clinics than fast-food restaurants. And just like fast-food restaurants, people will be fed a diet of health care that may taste good at the moment but will kill them in the long run.

—Robert H. Brown, MD, CCFP
Abbotsford, BC
by mail

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1. Borkenhagen RH. Walk-in clinics and time management. Fresh insights as family practices adapt [editorial]. *Can Fam Physician* 2002;48:437-9 (Eng), 446-9 (Fr).

De facto evidence for the no-stirrup method

I am a little behind in my reading like Dr Klassen said in his letter.[1] I, too, found Dr Michelle Greiver's article[2] on the no-stirrup method very interesting.

I have been in practice for almost 24 years and have always performed routine pelvic examinations without stirrups. Like Dr Klassen, I do occasionally use stirrups for certain procedures. I learned my technique from my father, a family physician trained in Britain. I have vivid recollections of arguments with my obstetrics and gynecology resident colleagues during my clinical clerkship and family medicine residency when I performed the examinations "my way." They insisted that my technique was faulty! The quality assurance statements on the reports of Pap smears that I have done suggest that my technique does not produce a higher than acceptable number of inadequate samples. I have found that patients universally prefer my method when they have had any other experience with which to compare it.

For the past 5 years, I have been responsible for teaching pelvic examination skills in the second undergraduate year of the curriculum at the College of Medicine at the University of Saskatchewan in Saskatoon. At the time I was asked to take this responsibility, I was told that one of the teaching objectives was that the students learn to do pelvic examinations without stirrups. We show a video of a pelvic examination in the traditional lithotomy position in stirrups. I then demonstrate the technique without using stirrups and have the students develop the rationale for a preference for the latter. Without exception, the students perceive the no-stirrup technique as preferable, for both the psychological and physical comfort of patients. Invariably, a few students wonder aloud whether the technique will be awkward in practice, but by the end of a 2-hour session, all demonstrate proficiency with the technique and express comfort in its performance.

I teach the students to perform the entire examination from the side (modified for either right- or left-handed examinations). The patient lies on the examination couch and draws her knees up to a comfortable angle. Her feet remain flat on the bed, about shoulder width apart. This position is preferable to the frog-leg position, because it allows the patient to abduct her thighs without the need for external rotation, which can be uncomfortable.

A small pillow or folded sheet can be placed under the patient's buttocks, if required. Specula are kept on a small electric heating pad in the examination table drawer, so that they are warm. The physician remains standing and works from the side rather than from the end of the bed. This positioning means that eye contact can be maintained, the physician is not placed in a position of physical intimacy with the patient, and the patient maintains control.

My continued teaching responsibility is de facto evidence that my obstetrics and gynecology colleagues have come around to "my way" some 25 years later!

—Anne Doig, MD, CCFP, FCFP
Saskatoon, Sask
by e-mail

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