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
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by fax

Treating persistent cough: caution!

I read with interest the Practice Tip by Peleg and Binyamin 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 have noted that inhaled topical lidocaine causes bronchoconstriction in a notable proportion of asthmatic patients. Groeben et al 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.

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
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by e-mail
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?” 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 in his editorial, by Reid 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 that accompanied Barnsley et al’s paper.

First, in the article, 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.

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References