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.

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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.

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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.

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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