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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

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.

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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!

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