Walk-in clinics in Ontario

An atmosphere of tension

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ABSTRACT

OBJECTIVE To explore family practice (FP), emergency department (ED), and walk-in clinic (WIC) physicians' perceptions and experiences regarding the effect of walk-in clinics on Ontario's health care system.

DESIGN Qualitative method of focus groups.

SETTING Hamilton, London, and Toronto, Ont.

PARTICIPANTS Sixty-three physicians participated in nine focus groups, each with four to nine participants. Family physicians, ED physicians, and WIC physicians attended separate focus groups.

METHOD Nine focus groups were conducted in three cities in Ontario. Physicians' opinions, perceptions, and experiences regarding the role and effect of WICs on Ontario's health care system were explored. Focus groups were audiotaped and comments transcribed verbatim. The qualitative data analysis program NUD*IST was used to organize the data during sequential thematic analysis.

MAIN FINDINGS Participants identified two key factors contributing to the evolution of WICs: patients' expectations for convenient health care and the perceived limited availability of family physicians. Participants thought these two related factors resulted in a gap in primary care services that WICs had filled. Throughout discussions, an atmosphere of tension permeated the focus groups. Tension seemed to arise from issues of duplication, competition, standards of practice and quality of care in WICs, the effect of environmental and personal factors on physicians' practice, and the practice philosophy adopted by WIC physicians.

CONCLUSION Both FP and ED participants acknowledged their contribution to the gap in primary care services. They appeared to attribute current problems in health care delivery to the perceived deficiencies of WICs. The outcome was a marked tension among participants.

RÉSUMÉ

OBJECTIF Examiner les perceptions et les expériences des pratiques familiales, des services d'urgence et des cliniques sans rendez-vous concernant les répercussions des cliniques sans rendez-vous sur le système de la santé en Ontario.

CONCEPTION La méthode qualitative des groupes témoins.

CONTEXTE Hamilton, London et Toronto, en Ontario.

PARTICIPANTS Neuf groupes témoins de quatre à neuf participants chacun regroupaient 63 médecins. Les médecins de famille, ceux des services d'urgence et ceux des cliniques sans rendez-vous participaient à des groupes distincts.

MÉTHODOLOGIE Neuf séances de groupes témoins ont eu lieu dans trois villes de l'Ontario. Les opinions et les perceptions des médecins et les expériences vécues concernant le rôle et les effets des cliniques sans rendez-vous sur le système des services de santé en Ontario faisaient l'objet de l'étude. Les séances des groupes témoins étaient enregistrées sur bande sonore et les propos ont été retranscrits mot à mot. Le programme d'analyse de données qualitatives NUD*IST a servi à organiser les données durant les analyses thématiques séquentielles.

PRINCIPAUX RÉSULTATS Les participants ont identifié deux principaux facteurs ayant contribué à l'évolution des cliniques sans rendez-vous: les attentes des patients à l'égard de services de santé opportuns et la perception d'une disponibilité limitée des médecins de famille. Les participants étaient d'avis que ces facteurs reliés entre eux se traduisaient par une lacune dans les services de première ligne qu'avaient su combler les cliniques sans rendez-vous. Dans le contexte des discussions, il se dégageait un climat de tension dans les groupes témoins. La tension semblait émaner de questions liées au chevauchement, à la compétition, aux normes de pratique et à la qualité de vie dans les cliniques sans rendez-vous, de l'influence des facteurs environnementaux et personnels sur la pratique des médecins et de la philosophie adoptée par les médecins des cliniques sans rendez-vous.

CONCLUSION Tant les médecins de famille que les médecins des services d'urgence ont reconnu leur contribution à la lacune dans les soins de première ligne. Ils semblaient attribuer les problèmes actuels dans la prestation des soins de première ligne à des faiblesses perçues dans les cliniques sans rendez-vous. Il a résulté des séances une tension marquée entre les participants.

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For almost two decades there has been controversy over the effect of walk-in clinics (WICs) on delivery of primary health care services.[1-9] Critics of WICs have highlighted issues of duplication and unnecessary competition,[1,7] and have also suggested that WICs disrupt continuity of care and potentially add expenses to an already costly health care system.[4-7]

In contrast, proponents of WICs emphasize the convenience they offer to highly mobile patients faced with multiple work and family demands.[6,9] These authors argue that WICs offer patients a reasonable alternative to overcrowded, short-staffed emergency departments (ED) and thus decrease the burden on EDs by providing nonurgent care.[6,9] Also, WICs address the problem of fully booked family practices that do not provide adequate after-hours care.[3,6]

The controversy and inherent tension surrounding the evolution of WICs has already been documented.[3,9,10] Despite the reported popularity of WICs among patients[4,6] and speculation regarding their effect on the organization of primary care,[5,6,9,11,12] little research has been conducted on the potential tensions among the various providers of primary care.

While the initial intention of this qualitative study was to explore participants' definitions, descriptions, and experiences of WICs, a prominent theme prevailed: the tension among providers of primary health care. Findings reported in this paper describe the strained atmosphere observed during the focus groups.

This study was part of a multicomponent, multicentre study called the Ontario Walk-in Clinic Study supported by a grant from The Physicians' Services Incorporated Foundation. Ethics approval was obtained from the review boards of all three participating institutions, the University of Toronto, the University of Western Ontario in London, and McMaster University in Hamilton, Ont.

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METHODS

This study used the qualitative method of focus groups to collect data.[13] Focus groups have been used extensively in the primary care setting to explore patients' and providers' perceptions and opinions of services and programs.[14-17] Three focus groups were conducted in each of Hamilton, London, and Toronto in spring 1997. The groups were composed of physicians who worked primarily in either EDs, WICs, or family practices (FPs).

Recruitment

Local investigators in each city recruited focus group participants. The method of recruitment varied somewhat from city to city; most FP and ED physicians were identified through family medicine and emergency medicine departmental mailing lists. Walk-in clinic physicians were recruited through contacting local WICs at each site. The overall objective was to recruit physicians who would reflect a variety of opinions and experiences from each site. In total, 63 participants attended the focus groups; there were four to nine participants in each group.

Focus group conduct

One of the investigators from each site assumed the role of moderator for the focus groups. A research assistant, present during all the focus groups, made field notes and provided a consistent link between the sites. All the focus groups, which ranged in length from 45 minutes to 2 hours, were audiotaped and transcribed verbatim.

Analysis

The researchers read the transcripts independently, initially looking for key words and emerging themes. After each focus group, researchers compared and combined their independent analyses during a conference call. This process allowed for exploration, expansion, and testing of themes in future focus groups. An extensive list of key words and themes was maintained and revised throughout the process, resulting in a final analysis template that allowed researchers to organize and code the data accordingly. It also assisted in determining that theme saturation had been achieved at the end of data collection.

All transcripts were coded using the analysis template and entered into a computer software program

designed to assist in organizing and managing qualitative data. At this stage of the analysis, three of the researchers (J.B.B., L.M.S., and T.Ø.) conducted a secondary analysis of the data examining similarities and differences across and within the focus groups and the relationships among identified themes. Several iterations of the findings were circulated among research team members for clarification and consensus before they were considered final.

FINDINGS

Of the 63 participating physicians, 48 were men and 15 women. More than 87% of participants had graduated from a Canadian medical school, and 62% had graduated after 1980. Primary site of practice reported by participants was 31% EDs, 32% WICs, and 37% FPs. In each of the FP and WIC focus groups, at least one participant described practising in both a WIC and a FP. For example, some physicians had initiated practice in WICs and that practice had ultimately evolved into full-time FP. These participants provided a double perspective on the study questions.

Evolution of walk-in clinics

All the focus groups viewed the evolution of WICs in Ontario's health care system as being influenced by changes in two key areas: patients' expectations of convenient health care and the perceived limited availability of family physicians.

> We should look at why people go to these things [WICs], and [there are] a couple of reasons… convenience and when doctors' offices are open.… People say, "Well you know, the emergency department, I can go and wait for hours and hours. My family doctor is closed.… Well what's out there? I'll go to the walk-in clinic. Why not?" It's a perfectly reasonable choice.

Participants suggested that the outcome of the interwoven factors of patients' expectations and family physicians' unavailability resulted in a gap in primary health care services. Walk-in clinics emerged in response to this gap: "There's a gap between emergency services and primary care services, and that's what the walk-in clinics have been filling up." Family physicians recognized their contribution to the gap in primary care services; some ED physicians also acknowledged their role. "We should really look at walk-in clinics as a failure of either primary care or emergency medicine to deliver the goods." As time had passed, participants described an expanding WIC service.

> If you look back at walk-in clinic history, the usual clinic hours were after 5 until midnight.… But as walk-in clinics evolved and gradually migrated into the regular office hours, they changed into a 7-day-a-week [operation].

But as WIC services expanded, focus group participants described a blurring of roles and responsibilities among primary care providers.

> Today the reality is that there really is just a tremendous similarity [between WICs and family practices] and therefore obviously a tremendous duplication of services. That's really the bottom line.

Atmosphere of tension

Throughout discussions of the evolution of WICs, an atmosphere of tension permeated the focus groups. This tension arose from issues of duplication and competition. In addition, participants discussed the standards of practice and quality of care upheld by WICs. The tension was also evident in exchanges about the influence of environmental and personal factors on physicians' practice behaviour. Finally, FP participants expressed their concerns about the practice philosophy adopted by WIC physicians, specifically the lack of patient-doctor relationships and continuity of care.

Duplication. Duplication of services was prominent throughout all focus group discussions. Duplication could be initiated by either patients or physicians. Participants perceived that patient-generated duplication occurred in all three primary care settings. For example, FP participants described how patients often contacted them following an encounter at a WIC to verify the recommended treatment. "Most of my patients that go to walk-in clinics use them for convenience and then come to see me right afterwards with a prescription in their hand."

Duplication of services could also occur when WIC physicians recommended that patients consult their family physicians for additional advice or referred them on to EDs. Family practice and ED focus group participants described this as physician-generated duplication, and it was principally a concern of ED physicians who viewed WICs as a "purely ineffective triage step."

> A number of patients have been referred from a walk-in clinic [to the emergency department] because they're seen in the walk-in clinic and require more care.… The

> patient's told, "go to emergency," so they show up and you start up all over again.

In contrast, WIC participants saw this as appropriate referral of patients, not duplication.

Competition. The ED and FP focus groups articulated a strong sense of competition with WICs: "They have chosen not to integrate with the existing docs; they've chosen to compete." Discussions about competition were dominated by potential monetary gains and losses: "It all comes down to money. I mean the bottom line, everyone is skirting around the issue, but it really comes down to money." There was a perception that WICs "were just skimming the easy stuff," which represented a loss of revenue for physicians working in FPs or EDs.

> These clinics take things off the top and leave the weak and dizzies to the emergency department or to the family doc offices, and that's what really offends people.

In addition, FP participants believed that loss of "bread and butter" problems deprived them of relief from more complex patient problems. Finally, ED participants expressed the view that WICs were an "expensive way" to provide after-hours care and saw emergency departments as the most cost-effective setting.

For the most part, WIC participants did not feel they were competing with other primary care settings. Rather, they viewed WICs as providing a cost-effective and convenient service: "I'd rather that the trivialities are treated in a walk-in clinic rather than the emergency room where the cost is so astronomical."

Standards of practice and quality of care. The tension created by issues of duplication and competition stimulated discussion about standards of practice and quality of care. Emergency department physicians had strong opinions about standards of practice and quality of care within WICs including a lack of standards, regulation, credentialing, and supervision. Although less adamant, FP participants also expressed concerns about standards of practice and quality of care in WICs: "I'm still concerned with the quality of care that people provide or receive when they go to a walk-in clinic."

There was little discussion about standards of practice and quality of care during the focus groups composed of WIC physicians. There was, however, ample discussion justifying their existence and addressing the commonly held criticisms of them. They cautioned about stereotyping all WIC physicians based on experiences from a few patient encounters or with a few physicians: "The supposition that the doctor becomes a moron the second he works in a walk-in clinic… that is very insulting."

Effect of environmental and personal factors on practice. The atmosphere of tension was accentuated by extensive debate during all focus groups as to whether practice environment or personal characteristics influenced physician practice. Some participants believed that physicians' behaviour was modified by the environment in which they practised.

> [In a WIC] you're just focused. You're here for this. Okay. Goodbye. Next. Whereas in a family practice you're looking at it from a different point of view.

In contrast, other participants believed that personal characteristics would guide their practice behaviour: "Whether I am in a family practice or I am working in a walk-in clinic, I will practise the way I practise." Finally, many participants recognized the complexity of physician practice behaviour and viewed both personal characteristics and the practice environment as modifying factors.

> I think the docs practise differently as well within the environment. In my environment…we have one doc that sees 10 patients an hour and I have four an hour. So it depends tremendously on the physicians' attitude, what's their background, what do they think they're there to accomplish?

Practice philosophy adopted by WICs. From FP participants' perspective, the existence of WICs threatened two fundamental tenets of family medicine: patient-doctor relationships and continuity of care. They emphasized the failure of WIC physicians to provide continuity of care and their concomitant inability to develop relationships with patients. They believed that development of patient-doctor relationships assisted family physicians in knowing patients' medical and personal histories, resulting in better outcomes and continuity of care.

> If my patient goes to a walk-in clinic tomorrow night and sees somebody for the first time, I know doggone well, even if the other doctor is equal in ability to me, I should have a better outcome on that one occasion. I should have a cheaper outcome because there should be information I know that I don't have to generate.

In contrast, WIC participants were adamant that this was not their role or responsibility.

> I get very upset if I see immunizations being done, Paps being done, because I don't think that's good continuing care;… that should be done by the family doctors.

Similarly, ED participants shared a common perspective with WIC participants in viewing continuity of care and patient-doctor relationships as the purview of family medicine.

DISCUSSION

From the participants' perspective, WICs had filled a gap in primary care services in Ontario that resulted from patients' expectation of convenient health care and the perceived limited availability of family physicians. Both FP and ED participants acknowledged their contribution to the gap in primary care services. They appeared to attribute current problems in health care delivery, however, to the perceived deficiencies of WICs. The outcome was a marked tension among the various providers of primary care.

Concerns about duplication of services are not new in discussion of the role of WICs.[4,5] Perhaps unique to our study was the concept of physician-generated duplication, which might represent a more controversial issue. Linked to duplication of service was the sense of competition. Competition was clearly driven by the economics of the system. From WIC participants' perspective, WICs existed to meet society's needs for convenient health care services. A powerful objection was expressed by ED and FP participants who viewed WICs solely as vehicles for making money. This could be interpreted as "turf protection," particularly at a time of health care reform when future roles of primary care providers remain uncertain or ambiguous.[18] Role conflict creates stress and subsequent breakdowns in communication, all of which intensify the tension among primary care providers.[18]

Two areas of tension, not clearly articulated in prior research, were the influence of environmental and personal factors on physicians' practice and the practice philosophy adopted by WIC physicians. As noted by our participants, the factors influencing physicians' behaviour are multifaceted and thus require further examination. While other authors have noted the perceived deterioration of patient-doctor relationships and continuity of care caused by WICs,[5-7,9,10,12] our findings provide a clear statement of concern by FP participants about these issues.

As primary care reform in Ontario moves forward, health care planners and policy makers must explore ways to balance patients' expectations for convenient health care and the number of physicians available and must recognize the tension that currently permeates the system. Two diametrically opposite solutions become apparent: elimination of WICs or full integration of WICs into the primary care system. Either option would address the issues of duplication and competition.

Integration of WICs would require a more seamless method of communication among all aspects of the primary care system. With integration, concerns expressed by participants regarding standards of

Editor's key points

- Patients' expectations for convenient health care and the perceived limited availability of family physicians have contributed most to development of walk-in clinics (WICs).
- This study revealed considerable tension between WIC physicians and those working in emergency departments or traditional family practices.
- The main issues contributing to tension were duplication of services, competition for fees, quality of care, type of practice in WICs (high volume, low complexity), and the practice philosophy of WIC physicians.

Points de repère du rédacteur

- Les attentes des patients à l'endroit de services de santé opportuns et la perception de la disponibilité limitée des médecins de famille ont contribué le plus à l'expansion des cliniques sans rendez-vous.
- Cette étude a révélé des tensions considérables entre les médecins des cliniques sans rendez-vous et ceux qui travaillent dans les départements d'urgence ou les pratiques familiales traditionnelles.
- La tension était principalement attribuable à la duplication des services, à la concurrence pour les honoraires, à la qualité de soins, au genre de pratique dans les cliniques sans rendez-vous (grand volume, faible complexité) et à la philosophie de pratique des médecins dans les cliniques sans rendez-vous.

practice and quality of care might be resolved by establishing clear lines of accountability and credentialing. Improved communication could also enhance continuity of care, even when there are many providers, and again address some of the issues surrounding standards of practice and quality of care. These options, however, could be met with resistance given the current tension among key players. Successful integration of WICs will necessitate clarifying the roles and expectations of each group of primary care providers—a task that can only be achieved through active participation by all concerned.

Limitations

This study was conducted in three cities located in southwestern and central Ontario; our findings might not be transferable to other locations. Also, at the time of recruitment, we were unaware that some participants had dual affiliations with both WICs and FPs. Their contributions to focus group discussions varied according to the "hat they were wearing." While the researchers needed to take this into consideration during analysis, it served to further elucidate the tension observed in the focus groups. Therefore, it was viewed as a benefit rather than a limitation in that it generated a more vigorous interchange among participants.

Conclusion

Our findings suggest that WICs exist as a consequence of patient and physician factors and that the controversy surrounding WICs has generated substantial tension among primary care providers. This tension was due mainly to duplication, competition, standards of practice and quality of care in WICs, the effect of environmental and personal factors on practice behaviour, and the practice philosophy adopted by WIC physicians. While this qualitative study reflects the subjective opinions and experiences of a select group of primary care providers, the findings raise many salient issues for further inquiry.

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Author contributions

Dr Brown *designed and implemented the study and data collection, supervised the analysis, and was principal author of the manuscript.* **Ms Sangster Bouck** *had a major role in data collection and analysis and in preparation of the manuscript.* **Dr Østbye** *contributed to secondary analysis and manuscript preparation.* **Dr Barnsley** *contributed to overall study design, data collection and analysis, and manuscript preparation.* **Dr Mathews** *and* **Dr Ogilvie** *contributed to data collection and preliminary data analysis, and commented on the final manuscript.*

Competing interests

None declared

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