
Family Practice Forum

The Emergi-Center and Family Practice in the 1980s

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A major approach to episodic primary care has emerged in American medicine. The "emergicenter," "minor emergency clinic," or "urgent care center," is regarded by some hospital and medical personnel as a major new development in providing primary care in response to public demand. These providers are saying that continuity of care is a myth, and they state they are providing what the public wants—low-cost convenient medical care. There are emergency centers springing up all over the United States, with many more on the drawing boards. This has been mostly a phenomenon of the urban and suburban population centers, but many smaller communities are beginning to see the growth of emergency centers in their areas as well.

How should family medicine approach this new phenomenon? Should we rise up in indignation about another example of the fragmentation of continuity in medical care? Must family physicians contemplate abandoning family lives and instituting evening hours in medical practice to provide convenience for and access to patients? It is important to examine what needs are being answered by the growth of the emergency centers in these communities, and what kind of continuity family physicians in practice really offer.

The last 15 to 20 years have seen major changes in practice style regarding after-hours availability. Many physicians 10 years ago were taking turns covering hospital emergency rooms and taking frequent calls from home; there was little time at home that was undisturbed by practice demands. When full-time staffed emergency rooms became established, these physicians realized that their lives were much improved. They could use an answering service and refer patients requiring emergency care to the full-time staffed emergency room nearby. Patients quickly understood that after standard office hours the new answering service would field calls and refer them either to an on-call physician or to the emergency room. Suddenly physicians were less accessible, and patients learned, without questions asked or telephone calls made, that they needed to go directly to the emergency room for their emergency medical needs. This kind of care, of course, is expensive, but since 70 to 80 percent of patients have third party insurance coverage, it mattered little to them that emergency room care cost at least twice what office charges would be for the same care. It was important that the care at the emergency room was convenient and available without significant delays.

Today a segment of the population is asking for accessibility and low cost in their medical care, and the minor emergency room is providing this kind of care. Taking a half-day off from work to go to the physician's office for a medical problem costs the patient more than the charge of an office

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K-Lyte® DS (Each effervescent tablet in solution supplies 50 mEq potassium as bicarbonate and citrate.)

K-Lyte® (Each effervescent tablet in solution supplies 25 mEq potassium as bicarbonate and citrate.)

Description: K-Lyte DS and K-Lyte are oral potassium supplements. Each K-Lyte DS tablet in solution provides 50 mEq potassium as supplied by 2.5 gm potassium bicarbonate and 2.7 gm potassium citrate with 2.1 gm citric acid, saccharin, artificial flavor and color. Each K-Lyte tablet in solution provides 25 mEq potassium as supplied by 2.5 gm potassium bicarbonate and 2.1 gm citric acid, saccharin, artificial flavor and color.

Indications and Usage: All K-Lyte® products are used for therapy or prophylaxis of potassium deficiency. They are useful when thiazide diuretics, corticosteroids, or diarrhea cause excessive potassium loss; and when dietary potassium is low. These products may also be useful when potassium therapy is indicated in digitalis intoxication.

Contraindications: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal impairment, metabolic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns or adrenal insufficiency. Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Warnings: In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and may be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Precautions: *General precautions*—The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. When interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. Therefore, the treatment of potassium depletion requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the ECG, and the clinical status of the patient.

Information for patients—To minimize the possibility of gastrointestinal irritation associated with the oral ingestion of concentrated potassium salt preparations, patients should be carefully directed to dissolve each dose completely in the stated amount of water.

Laboratory tests—Frequent clinical evaluation of the patient should include ECG and serum potassium determinations.

Drug interactions—The simultaneous administration of potassium supplements and a potassium-sparing diuretic can produce severe hyperkalemia (see Contraindications). Potassium supplements should be used cautiously in patients who are using salt substitutes because most of the latter contain substantial amounts of potassium. Such concomitant use could result in hyperkalemia.

Usage in pregnancy—Pregnancy Category C—Animal reproduction studies have not been conducted with any of the K-Lyte products. It is also not known whether these products can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. They should be given to a pregnant woman only if clearly needed.

Nursing mothers—Many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from oral potassium supplements, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Usage in children—Safety and effectiveness in children have not been established.

Adverse Reactions: The most common adverse reactions to oral potassium supplements are nausea, vomiting, diarrhea and abdominal discomfort. These side effects occur more frequently when the medication is not taken with food or is not diluted properly or dissolved completely.

Hyperkalemia occurs only rarely in patients with normal renal function receiving potassium supplements orally. Signs and symptoms of hyperkalemia are cardiac arrhythmias, mental confusion, unexplained anxiety, numbness or tingling in hands, feet or lips, shortness of breath or difficult breathing, unusual tiredness or weakness and weakness or heaviness of legs (see Contraindications, Warnings and Overdosage).

Dosage and Administration: *Adults*—One (1) K-Lyte DS tablet (50 mEq potassium) completely dissolved in 6 to 8 ounces of cold or ice water, 1 to 2 times daily, depending on the requirements of the patient. One (1) K-Lyte tablet (25 mEq potassium) completely dissolved in 3 to 4 ounces of cold or ice water, 2 to 4 times daily, depending on the requirements of the patient.

Note: It is suggested that all K-Lyte products be taken with meals and sipped slowly over a 5 to 10 minute period.

How Supplied: K-Lyte® Effervescent Tablets (orange or lime flavors) are available in cartons of 30, 100 and 250. K-Lyte® DS effervescent tablets (orange or lime flavors) are available in cartons of 30 and 100. Each tablet is individually foil wrapped.

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call. This becomes less a concern when the insurance system is paying for the medical care. Promoters of the minor emergency center care concept maintain that continuity of care is greatly overemphasized and that the public is demanding convenience and ease of access as well as low cost for their medical care.

Continuity of care is still essential to meaningful primary care. This need is evident when dealing with a member of a problem family with intense psychosocial problems or with a geriatric patient with a long and complicated list of problems. A minor emergency center provides nothing except episodic care. The problem, of course, comes because it is not possible to separate the episodic care from knowledge of the underlying psychosocial and other complicated interacting medical problems of patients. With the phenomenon of the minor emergency centers growing in a number of communities, however, primary care physicians will not be providing much continuity of care if they do not provide accessibility as well.

Through the years family physicians have not been particularly concerned with issues of practice competition or physician manpower supply. Family physicians have been able to consider practice locations on the basis of where they want to live and assume they would soon have a busy practice. As the physician supply increases in the next few years, it is likely that many family physicians will be concerned with issues of competition. Styles of family practice must accommodate patient needs for more convenient, low-cost medical care. Many individuals and families are mobile. They care about convenience and cost first and continuity second. Family physicians will not be seeing these patients unless family medicine provides an alternative to the care provided by the minor emergency center. Family physicians in group practice or associations will need to explore ways of providing some evening and weekend medical care. Family physicians may want to consider taking after-hours calls at the office rather than at home. Indeed, many group practices have already established evening and weekend cover on this basis in the past year. Emergency rooms, the medi-center concept, and the changing atmosphere of physician supply have changed the equation and those in family medicine will need to accommodate to this new reality.