

# JUCM™

THE JOURNAL OF **URGENT CARE** MEDICINE®

APRIL 2010  
VOLUME 4, NUMBER 7

www.jucm.com | The Official Publication of the Urgent Care Association of America

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## Assessing Abnormal Uterine Bleeding in the Urgent Care Setting

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## LETTER FROM THE EDITOR-IN-CHIEF

# A Disconnected World



Texting, chatting, networking, blogging, and posting. The evolution of communication into characters on a screen...digitized snippets, factoids, and acronyms used to express, display, inform, and explain. Even emotions have been whittled down into emoticons....a semicolon “wink” and a parenthetical “frown.” E-mail? That is soooo last decade!

Electronic communication technology has practically replaced more traditional forms. So what does this mean? What is the impact on socialization, relation, and emotional connection? Are there any negative effects? Are there public health implications?

To date, very little scientific inquiry has been directed at the sociologic, psychologic, and neurologic impact of electronic communication and social networking. Yet, no single technology since the telephone has had the potential to produce such expansive evolutionary change.

Electronic communication has revolutionized everything from business and education to casual social interaction. What negative effects, if any, have been observed?

The most-cited risk is a function of the technology itself: personal and social cues are all but absent, and can lead to the “depersonalization” of communication. While depersonalization can be an unwanted side effect of electronic communication, it is, at times, sought out for this very effect. Scientific observers have noted a gravitation toward electronic communication when the user is intentionally avoiding unwanted social interaction. The great and powerful Oz is a confident communicator...but, “pay no attention to the man behind the curtain!”

Perhaps the most critical evolutionary impact of depersonalization is occurring in children. You’ve all witnessed this curious scene: two teenagers sitting side by side texting to each other. Close enough to speak, for sure, but the teens would rather text than talk. Why?

Writing and speaking are two different neural activities.

When writing, the communicator can think about what he/she wants to say before putting pen to paper (or thumb to keypad, as it may be).

Speaking involves what you might call a “social undressing.” The curtain is pulled and the speaker is confronted with the judgments of those in the audience. Visual and verbal references are flying all around, and the communicator must react and respond in perfect symphony in order to be effective. Spoken

communication is a dance requiring a mental agility not seen in written communication. The ability to communicate orally, with all of the potential for error and embarrassment, is an important mental exercise that builds confidence and relational skills that writing—err, texting—cannot.

Susan Greenfield, a professor of synaptic pharmacology at Oxford, has written extensively on the social and biological implications of electronic social networking on the growing mind. She warns, “Real conversation in real time may eventually give way to these sanitized and easier screen dialogues, in much the same way as killing, skinning, and butchering an animal to eat has been replaced by the convenience of packages of meat on the supermarket shelf. Perhaps future generations will recoil with similar horror at the messiness, unpredictability, and immediate personal involvement of a three-dimensional, real-time interaction.”

Additional concerns have been raised about the impact of virtual communication on everything from attention span to addiction, self-identity to sensationalism, and a disordered sense of reality.

The very technology that was created to help us “connect and network” may very well be creating the ultimate evolutionary paradox.

It is time for healthcare professionals to respond to this impending public health crisis. Consider what I would call an assessment of “social connectivity” at every visit. Your history might include: How many hours a day do you spend “virtually” communicating compared with face to face? Are electronic devices allowed at the dinner table? Are you comfortable talking with peers and with adults? Do you avoid situations that require direct communication?

Consider these depersonalized communication disorders as the “textually transmitted diseases” of the 21st century!

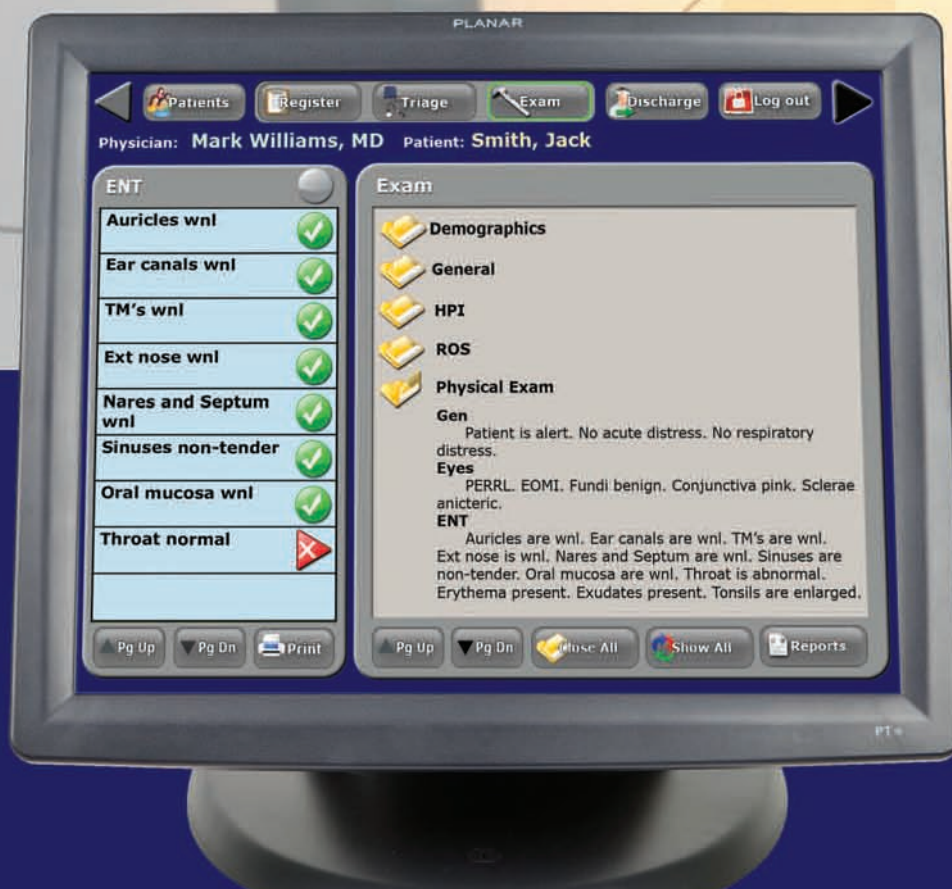
Test, treat, and prevent! ■

Lee A. Resnick, MD  
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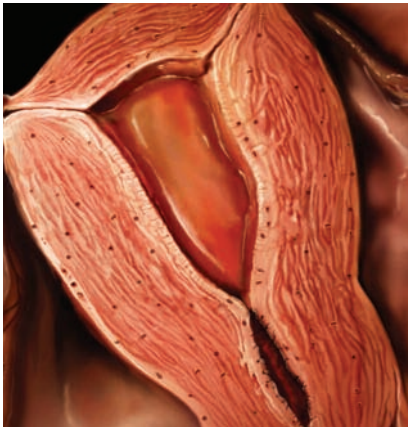
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## April 2010

VOLUME 4, NUMBER 7



### CLINICAL

## 9 Assessing Abnormal Uterine Bleeding in the Urgent Care Center

Over a million outpatient visits every year are attributed to gynecologic exam. Familiarity with patient concerns, common etiologies, and special populations are key to proper assessment in urgent care.

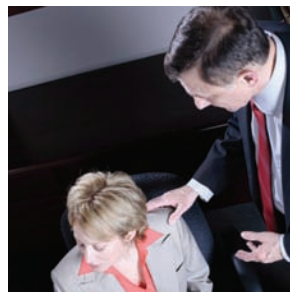
By Thomas Sunshine, MD

### PRACTICE MANAGEMENT

## 27 Protecting the Urgent Care Center from Sexual Harassment Claims

Like any other workplace, urgent care centers must also be vigilant for improper behavior among staff members or between management and subordinates. Firm, well-defined policies must be in place—and communicated clearly to all parties.

By Alan Ayers, MA, MAcc



### WEB EXCLUSIVE

#### Fever Phobia

Fear of fever leads many parents to seek urgent care for their children. Addressing their concerns should be part of the care of febrile children. Available only at [www.jucm.com](http://www.jucm.com).

By Deena R. Zimmerman, MD, MPH, IBCLC; Nahum Kovalski, MD; Baruch Hain, BA; and Joshua Lipsitz, PhD

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### IN THE NEXT ISSUE OF JUCM

Many infections and injuries of the ear, nose, or throat are unique to the pediatric population—and many are deemed by parents to be urgent enough to require immediate attention. An overview of the more common ENT issues with which children are likely to present.

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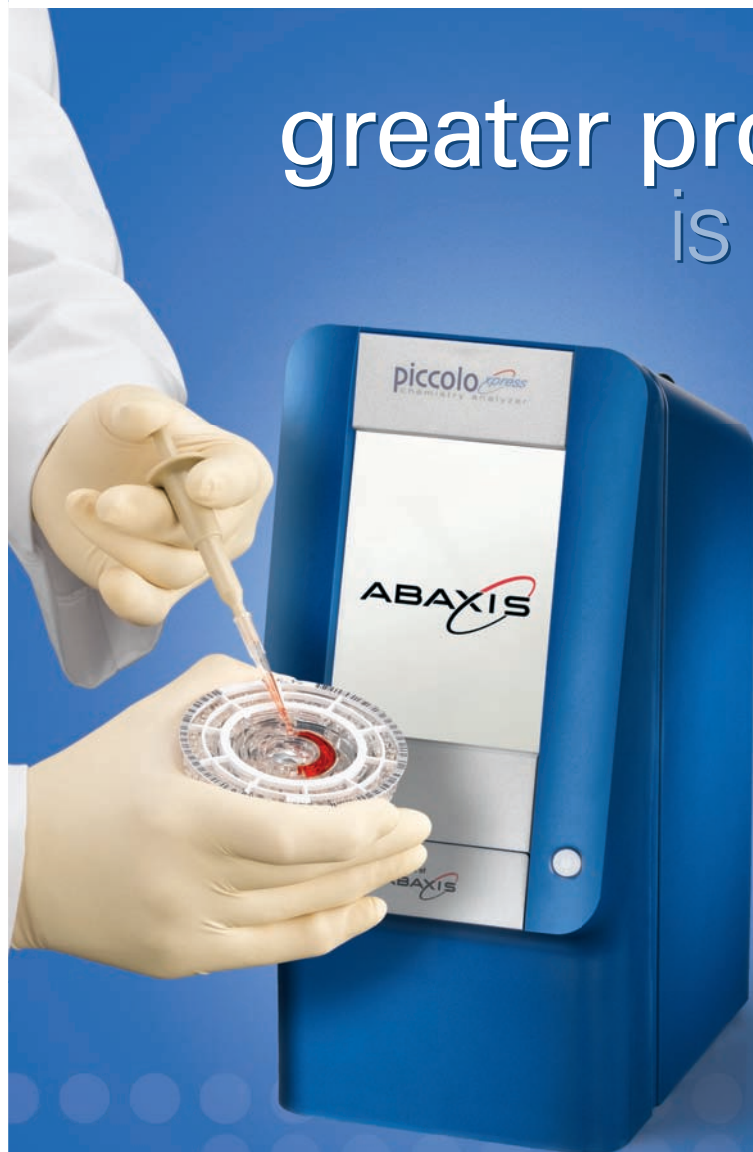
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**JUCM** (ISSN 1938-002X) printed edition is published monthly except for August for \$50.00 by Braveheart Group LLC, 65 North Franklin Turnpike, Second Floor, Ramsey, NJ 07446. **JUCM** is pending periodical status at Mahwah Postal Annex, 46 Industrial Drive, Mahwah, NJ 07430 and additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 65 North Franklin Turnpike, Second Floor, Ramsey NJ 07446.



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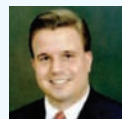
One of the key, distinguishing factors that draws patients to urgent care—efficient assessment of most non-life-threatening conditions—can also be a challenge for the practitioner who may be more well-versed in some areas than others.

Your experience in the ED may have left you expert in managing fractures or acute chest pain, but would you be prepared if a nervous single dad brought in an adolescent daughter with concerns about her first experience with menstruation? How would your assessment differ if the patient were going through perimenopause, or is of unknown gravid status?

In *Assessing Abnormal Uterine Bleeding* in the Urgent Care Center (page 9), **Thomas Sunshine, MD, FACOG** draws on 15 years of experience as an OB/GYN and current work as an urgent care provider in Idaho to offer a review of common etiologies, patient history, and demographic consideration.



Dr. Sunshine has published articles and delivered presentations in the OB/GYN arena, and we're fortunate that he has offered to share that expertise with *JUCM*.



One concern that does *not* distinguish urgent care from other settings—or from other workplaces in general, for that matter—is vulnerability to accusations of sexual impropriety. As **Alan Ayers, MA, MAcc** explains in *Protecting the Urgent Care Center from Sexual Harassment Claims* (page 27), clear, well-defined policies on acceptable behavior among all employees goes a long way toward helping staff members feel safe when they come to work.

Mr. Ayers is practice management content advisor to the Urgent Care Association of America and vice president of strategy and execution for Concentra Urgent Care in Dallas.

And, exclusively at [www.jucm.com](http://www.jucm.com), **Deena Zimmerman, MD, MPH, IBCLC**; **Nahum Kovalski MD**; **Baruch Hain BA**; and

**Joshua Lipsitz PhD** offer insight, backed up by their own data, into Fever Phobia—Urgent Fears in Urgent Care. This team of authors from Terem Emergency Medical Centers and Ben Gurion University of the Negev in Israel maintains that addressing parental concerns that “something bad” will happen to a child by virtue of high fever, while not as immediate a concern as examining the patient, is of key importance in the overall patient encounter.

### Also in this issue:

- **Emory Petrack, MD, FAAP, FACEP** offers advice on red flags to be on the lookout for when challenged with examining the well-appearing irritable infant.
- **Nahum Kovalski, BSc, MDCM** reviews new abstracts on diagnostic medical errors, older patients with syncope, the value of muscle relaxants in cervical strain, low back pain, and diagnosis and management of red eye.
- **John Shufeldt, MD, JD, MBA, FACEP** warns of the five markers that a business is in trouble. Toyota may not have recognized them; would you?
- **Frank Leone, MBA, MPH** reasons that a business that has cut back on its workforce may actually be a good prospect for a pitch for the wellness services you offer.
- **David Stern, MD, CPC** responds to readers' questions about coding x-rays ordered by providers outside your urgent care center, G-code for drug testing, and 99051 for scheduled visits.

Do you have an idea for an article, case report, or insight to be gleaned from an x-ray or electrocardiogram? Describe it an e-mail to our editor-in-chief, **Lee A. Resnick, MD**, *JUCM*'s editor-in-chief, at [editor@jucm.com](mailto:editor@jucm.com). We want each issue of *JUCM* to reflect your experiences so others can benefit from what you've learned. ■

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Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

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## FROM THE EXECUTIVE DIRECTOR

# When Words Won't Do

■ LOU ELLEN HORWITZ, MA

Sometimes, writing this column is the easiest thing in the world—but not often. Sometimes, it is hard to conjure up a compelling topic, and sometimes (like now) it's hard to choose between way too many, especially with the National Urgent Care Convention right around the corner.

I re-read an article yesterday that was written by Dr. David Stern in *Emergency Medicine Review*; it began, "The year #### has been the most dramatic year ever for the rapidly growing urgent care industry." The wonderful and challenging thing about our industry is that the "####" could easily be replaced by this year, last year, the year before, etc. It seems like *every* subsequent year is the "most dramatic year ever"! (For the record, the actual year referred to was 2005.)

In the UCAOA offices, we see this firsthand. The questions our members ask continue to grow more complex. The non-member callers are much more diverse.

Every week, we hear from the media, venture capitalists, state governments and medical societies, fellow association leaders, prospective urgent care owners or franchisees, bankers, lawyers, real estate agents, patients...you name it. The number of stakeholders in urgent care has grown exponentially.

This is probably even more apparent to our members who are operating on a regional or national level, as you have to navigate the various obstacles to expanding your organization's reach. As time goes on, those only seem to increase in number, as various other parties see urgent care as competition and create additional roadblocks. At times, it makes me wonder if there's a *patient* shortage we should all be discussing instead of a physician shortage.

For the vast majority of you, however, your primary ongoing focus is getting your individual center through the day/week/month/year in a quality-driven, patient-centered, ethical and profitable manner. It is the baseline of what all successful centers do: deliver efficient, effective, episodic care.



**Lou Ellen Horwitz** is executive director of the Urgent Care Association of America. She may be contacted at [lhorwitz@ucaoa.org](mailto:lhorwitz@ucaoa.org).

Which brings me to a recent experience I wanted to share that picks up on a theme started by our editor-in-chief in the March issue of *JUCM* (Are You Really Listening?).

Most patients are really terrible communicators; I speak from being one myself. This winter I slipped on some ice and sprained my ankle. I hobbled around for a while, unwilling to go to a doctor because: 1) it was probably nothing and would go away on its own, 2) it's early in the year and I haven't met my deductible, 3) what could they tell me that I didn't already know? It's sprained; I'm familiar with the RICE routine.

After several days with little improvement, I did the next "natural" thing: I looked on the Internet. Outcome: confused.

Next, I started bothering my physician contacts and attempted a plan called "diagnosis by e-mail." Outcome: not really possible.

Finally, I headed into urgent care. Outcome: answer with a bonus.

While the x-ray did not show an ankle fracture, the sharp-eyed physician/radiologist team found a bone spur—a completely unrelated problem that I never mentioned during the visit, but one that had been bothering me for weeks via heel pain of unknown origin (which, obviously, I never saw a doctor about).

As I said, I'm speaking from experience. Patients don't communicate, so sometimes caregivers have to "listen" with their eyes, not just their ears.

Why am I sharing this story? Because it goes back to the core of what you are all doing amidst the turmoil swirling around our country and our industry. It all goes back to you and the patient.

It goes back to the fact that after all the external forces are done with you (as if they ever will be), it comes down to an 8 x 10 room in your center, with a hurting person who is not going to do a very good job telling you what they need—and yet you have to figure it out anyway. Ultimately, the Internet can't do that.

So, while there's plenty to say about the shifting sands we all tread on—and those sands blow around a lot—they actually *shift* pretty slowly. We all need to keep an eye on them, but right now you have patients waiting to see you. ■



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# Assessing Abnormal Uterine Bleeding in the Urgent Care Center

**Urgent message:** Vaginal bleeding is a common presentation in the urgent care setting. An assessment of hemodynamic status, as well as an understanding of potential causes, is necessary to initiate treatment and triage the patient correctly.

Thomas Sunshine, MD

### Introduction

Patients presenting with what they perceive to be vaginal bleeding will not know whether that bleeding is specifically uterine, cervical, or (rarely) vaginal in origin. It is incumbent upon the urgent care provider to have a sound working knowledge of the many terms in the lexicon to describe such bleeding, and to be able to identify its source in order to appropriately direct treatment.

*Abnormal uterine bleeding* (AUB) encompasses both ovulatory and anovulatory uterine bleeding.

*Dysfunctional uterine bleeding* implies hormonal origin and is less specific.

*Menorrhagia* is excessive uterine bleeding at the time



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of the menstrual cycle, defined as menstrual blood loss of >80 cc per cycle or bleeding more than seven days.

*Metrorrhagia* is uterine bleeding occurring at times separate from defined menstrual bleeding.

*Dysmenorrhea* implies pain associated with the menstrual bleeding.

Simply knowing the vocabulary is not enough to effectively manage such patients, of course. One must bear in mind quantifying factors such as different pad or tampon size with differing absorbencies, differing

patient criteria for changing, and saturation.

This article will offer a systematic review of possible etiologies, patient history and demographic considera-



tions, and discussion of special patient populations.

### **Etiology**

Likely etiologies of AUB vary broadly. Recognition of demographic and historic factors can help guide the clinician in identifying the likely cause.

For example, an adolescent who just recently started her menstrual cycles will present different considerations than those of a post-menopausal woman or one who has had an established menstrual history. A complete evaluation of the premenarchal patient will not be addressed in this paper, but basic consideration in this age group should include foreign body, infection, trauma or abuse, and, rarely, bleeding secondary to tumor.

Abnormal bleeding in a pregnant patient must also be assessed uniquely.

Common to the evaluation of all these patients is the initial assessment of hemodynamic status, which is familiar to the urgent care provider already. Following this, the initial work-up and treatment are determined by the etiology of the bleeding.

#### *Adolescent patients*

The occurrence of “irregular” bleeding is common in adolescent patients. If the cycle fits the expectations of physiologic variation, it requires an assessment of hemodynamic parameters, excluding coagulopathy and then reassurance, or, occasionally, treatment.

While the median age for menarche across all demographics is 12.43-years-old, only 10% of girls will start their menses by age 11, and 90% will have started by 13.75 years old. It is noteworthy that the average age of menarche is slightly younger in blacks and Hispanics and in those patients with a higher body mass index.

Thus, while menarche occurring before age 11 may not be abnormal, it should be considered in respect to other signs of the development of secondary sexual characteristics.

Once menarche is established, not all girls will follow the same pattern and, thus, may present with complaints of “irregular” bleeding which may or may not be physiologic. Knowing the range of what can be considered “normal” allows the provider to decide whether further evaluation is warranted.

It is expected that anovulation will occur during the first year after menarche. By three years following menarche, 70% of females will establish a cycle interval lasting between 21 and 34 days. However, in the first years, 5% will experience an interval at 23 days; 5% will

experience intervals >90 days. Despite this wide range, the duration of the cycle should still not be longer than seven days.

#### *von Willebrand's disease*

With any bleeding heavier than average, the clinician should be alert for undiagnosed coagulopathies, particularly von Willebrand's disease. With an estimated prevalence of 1%, it is a common medical diagnosis associated with menorrhagia at menarche. History may reveal episodes of bruising, nosebleeds, or mucosal bleeding, as well. Many coagulopathies are inherited, including von Willebrand's, so family history may be relevant and helpful.

#### *Polycystic ovary disease*

Polycystic ovary disease, known alternately as Stein-Leventhal syndrome and PCO, should also be considered when menstrual irregularities occur with signs of hyperandrogenism or insulin resistance. Evaluation may demonstrate hirsutism, acne, or androgenic alopecia with evidence of metabolic syndrome. The etiology of PCO is uncertain, but may be related to either overproduction of ovarian androgens, excess pituitary luteinizing hormone (LH), or hyperinsulinism.

#### *Structural abnormalities*

Structural abnormalities such as polyps, fibroids, and tumor are unlikely in adolescents. As the age of the patient increases, however, anatomic causes become more prevalent. It is estimated that as many as 70% of white women and 80% of black women by age 50 have leiomyoma. Pedunculated and submucosal fibroids are most likely to cause irregular bleeding, as intramural, subserosal, and pedunculated fibroids do not directly communicate with the endometrial cavity. Imaging studies, primarily ultrasound, are needed to precisely define the nature and location of suspected fibroids.

Polyps can arise from either the cervix or the endometrium. Visual inspection is usually all that is necessary to diagnose an endocervical polyp, but those of endometrial origin would require an imaging study. Removal of an endocervical polyp could be accomplished in the urgent care setting. Although almost always benign, sending the specimen for definitive pathology is appropriate. Bleeding at the base of the polyp, from where it was removed, is generally easily controlled by a variety of hemostatic techniques.

Endometrial adenocarcinoma is the most likely malignant cause of AUB. Although less likely to present to

urgent care for vaginal bleeding, postmenopausal patients with any bleeding warrant evaluation. Attention should be given specifically to anatomic causes, with concern for malignancy, atrophic bleeding, and bleeding disorders. Outpatient endometrial biopsy is a procedure readily adaptable to the urgent care setting.

#### *Anovulation*

In the patient group outside of the initial menarchal period and up to menopause, anovulation is the most likely etiology.

In the anovulatory patient, no corpus luteum forms, and the endometrium experiences excessive estrogen exposure. Such endometrial growth is comprised of both glands and vessels, yet without progesterone from the corpus luteum, there is not adequate stromal support to sustain endometrial stability; bleeding ensues. However, not all areas will bleed simultaneously, giving rise to the irregular nature of the vaginal bleeding (metrorrhagia).

**Table 1. Common Causes of Anovulatory Bleeding**

Physiologic	<ul style="list-style-type: none"> <li>■ Menarche</li> <li>■ Perimenopause</li> <li>■ Breastfeeding</li> <li>■ Medications</li> </ul>
Pathologic	<ul style="list-style-type: none"> <li>■ Abnormalities of central hypothalamic-pituitary hormonal axis</li> <li>■ Abnormalities of ovarian hormones</li> </ul>

Causes of anovulatory bleeding are numerous, but can be simplified in terms of those that are secondary to normal physiologic processes such as adolescence, perimenopause, and lactation, and those with pathologic causes secondary to endocrinologic disorders, systemic disorders, ovarian factors, and external factors such as medications (Table 1).



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## Assessment

The initial evaluation of the hemodynamic status of the patient with bleeding is familiar to the urgent care provider. Treatment of the unstable patient will depend on the capabilities of the particular setting.

In cases where there is an anatomic cause of irregular bleeding, there may well be a normal cyclic, ovulatory pattern, as well. When evaluating the bleeding pattern, it is helpful if the patient can differentiate from her normal menses, often associated with premenstrual symptoms indicative of ovulation. The pattern of bleeding may be consistent with ovulation and feature normal menstrual bleeding, as well as intermenstrual bleeding, metrorrhagia. Or, the pattern may be solely irregular bleeding consistent with anovulation. Thus, while developing the history of the bleeding pattern, it is not as helpful to focus on diagnostic terms as it is to differentiate between ovulatory or anovulatory bleeding.

The provider should evaluate the patient for endocrine disease, looking for signs and symptoms of thyroid, cortisol, prolactin, and sex hormone disorders.

In addition, the history should review clues for coagulopathies. Medicines, specifically psychotropics, can interfere with ovulation. Chronic systemic illness, such as diabetes, liver disease, or hypertension, is also associated with anovulation.

The physical exam should include thyroid size and symmetry, evidence of acanthosis nigricans, evaluation of hirsutism, or even virilization.

When performing the pelvic exam, initial speculum exam will sometimes reveal a vaginal or cervical source for the bleeding. In the sexually active patient, infections with either endocervicitis or endometritis can produce irregular bleeding based on capillary fragility associated with stromal inflammation. A full screening for sexually transmitted disease screen would be advisable if this is suspected. In this setting, swabbing the endocervix may produce bleeding. In fact, postcoital bleeding may be the presenting symptom.

Bimanual pelvic exam should be performed to evaluate anatomic pelvic abnormalities such as fibroids or ovarian cysts. However, even in the best hands pelvic exam is not sufficient to detect intracavitary fibroids or polyps, necessitating ultrasound.

## Treatment

In the non-pregnant patient, AUB can represent the urgent problem itself if associated with hemodynamic compromise.

If active bleeding is associated with orthostatic

changes and low hemoglobin level, then referral to a facility that can provide both transfusion and possible surgical intervention will be necessary. However, if the patient is stable, then treatment of the bleeding depends on whether the source is irregular endometrial shedding associated with anovulation, is from an anatomic source such as fibroid or polyp, or is from other cause.

Pharmacologic treatment for the irregular endometrial shedding and bleeding relies upon the vessel stabilization effects of estrogen, and the stromal effects of a progestin. When using a combined hormonal approach, the drawback is that the combination produces some endometrial growth which may subsequently result in heavier bleeding. Such is the drawback with high-dose estrogen, as well.

Hormonal monotherapy with either a progestin or estrogen can be employed with differing expectations. Many providers use a progestin only for anovulatory bleeding. The endometrium, being at varying stages of maturation, is then converted to a uniform state of maturation prepared for shedding, similar to the natural menstrual cycle. The bleeding should occur a few days following the course of progestin.

Some of the different proposals, in summary:

- Low-dose OCP qid x 3 d, tid x 3d, bid x 3 d then qd until stopped for menses
- Conjugated equine estrogen 10 to 20 mg/day PO (2.5 mg – 5 mg qid)
- IV Estrogen 25 mg q 4 x 24 hours
- 10 mg medroxyprogesterone qd PO x 10 days

## Pregnant patients

The importance of establishing whether the patient with AUB is pregnant cannot be understated. There are many different brands of tests to detect the presence of HCG in the urine, and it is important for the provider to be familiar with the specifics of the one they rely upon. Many providers have come to consider the pregnancy test a “vital sign” of a woman with abdominal pain or vaginal bleeding.

Most such tests will detect enough HCG in the urine at 10 to 14 days post-conception to be positive. In some circumstances, the urinary qualitative test may be more accurate than a qualitative blood test due to the presence of serum heterophilic antibodies to the assay's anti-HCG antibody. Such heterophilic antibodies are produced in response to animal-derived antigens, and are thus more common in patients with animal exposures. The heterophilic antibodies are not present in urine. Thus, care needs to be exercised when interpret-



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ing a serum qualitative result.

A menstrual history and gestational history should focus on risk factors for miscarriage and ectopic pregnancy. Prior tubal infection or surgery is significant, as roughly one third of all pregnancies following sterilization are ectopic. However, half of women with an ectopic pregnancy have no risk factors or physical finding. Last menstrual period may be reliable in a woman with regular cycles, but one must use caution when seeking to rely on this factor to determine the duration of pregnancy.

Most providers will not have a quantitative HCG level available in a timely fashion and will make a determination based on history, risk factors, and physical exam. However the provider should be familiar with the discriminatory zone for transvaginal ultrasound (TVUS) at their institution. These will usually be in the range of a serum HCG level between 1,500 mIU/mL and 2,000 mIU/mL; this is the HCG level at which the findings on TVUS should confirm an intrauterine singleton pregnancy based on a gestational sac either with or without a yolk sac, as well. There are exceptions to this, such as multifetal gestations or guided intrafallopian transfer. The risk of simultaneous intrauterine pregnancy and co-existent tubal pregnancy is approximately 1/3,000.

Though serum progesterone levels may not be applicable to the decision-making in the urgent care setting, they may be useful in longer-term management. Low progesterone level ( $<5$  ng/mL) is highly associated with an abnormal pregnancy; levels  $>20$  ng/mL are associated with normal pregnancy.

Also helpful in long-term assessment will be serial HCG levels. In a normal pregnancy, the HCG level should double every 1.4 to 2.1 days, but there are many different interpretations as to what constitutes a “normal” rise, and this must always be used in conjunction with other testing and the clinical picture.

Bleeding from a pregnancy located within the uterus during the first trimester can be associated with a viable or nonviable pregnancy. Such pregnancies are described as threatened abortion, incomplete abortion, or complete abortion.

(An important note regarding patient communications: Experience should tell us to be quite careful using the term “abortion” when discussing this with the patient. Be prepared to answer concerns and engage in patient education.)

A *threatened abortion* occurs with first trimester bleeding, a closed cervical os, and ultrasound or laboratory findings, if present, still consistent with a normal pregnancy. This is often assumed to be a result of implantation bleeding.

If the cervix is open or tissue has been passed, then it is an *incomplete abortion*.

If all the tissue has been passed, then it is a *complete spontaneous abortion*; however, this is typically a diagnosis made after HCG follow-up.

The management of first trimester bleeding starts with establishing hemodynamic status and patient comfort. Either one of these may indicate the need for emergent uterine evacuation or laparoscopy for ectopic pregnancy. Not every patient with an incomplete abortion needs to undergo a surgical evacuation, and the decision to proceed with one depends on the patient’s hemodynamic status and personal choice.

In such a situation, consultation with an obstetrician should be considered.

Once beyond the first trimester, patients typically have a known estimated gestational age (EGA), with the evaluation including both fetus and mother. A specific age for fetal viability is not established, and is more strongly correlated with fetal weight.

Following the first trimester, it is safer to assume there is no estimated EGA that can completely eliminate concerns over potential viability, as many procedures (including tocolysis and cerclage) may delay a delivery long enough for a pregnancy to reach viability. Since the diagnostic considerations include cervical incompetence, preterm labor, abruptio placenta, and placenta previa, the evaluation should be done in a setting suitable for surgical interventions; transfer is appropriate.

Some ectopics are now managed medically using methotrexate (MTX) if they are less than 3.5 cm dilated, unruptured, and have no fetal cardiac activity. Serum HCG level will determine dosing, and many treatment protocols exist.

It is important to note that MTX is a folic acid antagonist which inhibits DNA metabolism, with greatest impact on rapidly dividing cells. When MTX is used, be sure to instruct the patient to discontinue prenatal vitamins or other folic acid supplementation.

Other diagnoses, besides ectopic pregnancy and miscarriage, to consider with pain and bleeding in the first trimester include intrauterine pregnancy (IUP) with ruptured corpus luteum, appendicitis or abdominal pathology, and ovarian or fibroid torsion. When considering ruptured corpus luteum cyst, supplementation with natural progesterone should be provided.

First trimester vaginal bleeding in the presence of fetal cardiac activity either threatens miscarriage or, if the cervix is opened or tissue has been passed, portends an inevitable miscarriage. Care should be taken, because

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## ASSESSING ABNORMAL UTERINE BLEEDING

the external os of the multiparous patient can be open, giving the impression of a dilated cervix, yet the internal os remains tightly closed. In addition, retracted fibrin in aged clots can take on a whitish appearance similar to actual products of conception.

The treatment for threatened miscarriage is expectant management. The patient's hemoglobin and blood type should be checked and Rh sensitization prophylaxis given as indicated. Treatment for inevitable or incomplete miscarriage can be individualized to the patient, with both uterine evacuation and expectant management allowing the patient to pass the products spontaneously; both are acceptable. With expectant management, close follow-up is needed to monitor hemoglobin, evidence of infection, and following the HCG to zero.

### Summary

Occasionally, most urgent care clinicians will encounter a patient whose visit was initiated by concern over abnormal gynecologic bleeding. Managing such encounters effectively requires a working understanding of likely etiologies and the role demographics and history play in considering differential diagnoses, as well as an appropriate level of suspicion regarding the patient's confirmed or suspected gravidity. Each of these factors will influence the decision to treat, to consult, or refer to a specialist. ■

### Resources

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## The Irritable Infant

■ Emory Petrack, MD, FAAP, FACEP

Saturday morning. A mom appears at your urgent care center, looking tired and frustrated. She says that she was up much of the night with her 3-month-old son, who was crying and fussy. The baby has not had any fever, she tells you, but has not been feeding as well as he normally does.

On first look, the infant seems to be well appearing, but you are concerned that he is quite young, and you want to be sure you are not missing something more serious.

Where would you start?

A common, yet challenging presenting complaint for any provider is the “irritable infant.” While the vast majority of infants presenting with this chief complaint are ultimately well or have only a mild illness or injury, it is important to consider and rule out more serious causes (**Table 1**). A careful, stepwise approach to the evaluation of the irritable infant often leads to a diagnosis—the key to developing an appropriate management plan.

### Distinguishing Atypical Irritability

All infants are irritable at times, so defining exactly when irritability becomes concerning can be difficult.

The term *irritable infant* refers to a pediatric patient less than 1 year of age whom the caregiver deems to be excessively fussy, cranky, or crying. Frequently, the fussiness will have subsided by the time the child is seen by the clinician.

The vast majority of infants who are seen for irritability are stable. Nevertheless, as with any potentially ill patient, initial attention is given to evaluation and stabilization of the airway, breathing, and circulation. Once this is accomplished,

**Table 1. Serious Causes of Infant Irritability**

Acute surgical abdomen
Congestive heart failure
Corneal abrasion
Electrolyte disturbance
Foreign body
Hair tourniquet
Incarcerated hernia
Intussusception
Physical abuse
Serious infectious illness
Supraventricular tachycardia
Testicular torsion

attention can be directed toward a thorough history and physical examination.

In a study by Poole,<sup>1</sup> of 56 infants without fever presenting with excessive crying, history contributed to the diagnosis in 11 patients (20%).

Physical examination revealed the final diagnosis in 23 patients (41%), while contributing to the diagnosis in another seven patients (13%).

Laboratory studies, electrocardiography, or radiologic studies were required to establish the final diagnosis in 11 patients (20%).

Notably, final diagnoses were established in 22 patients (39%) through follow-up alone, emphasizing the importance of ensuring appropriate care after discharge.

The author notes that in his population, the presence of evidence of significant illness during evaluation, or persistent crying beyond the initial assessment, was predictive of serious illness with a sensitivity of 100%, specificity of 77%, and positive predictive value of 87%. In addition, no infant with a normal evaluation and lack of persistent crying after



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*“A complete and thorough physical examination... should include completely undressing the infant and examining all parts of the body.”*

the assessment was found to have serious illness.

A thorough history can aid in the differentiation of infants at risk for serious illness from those in whom underlying serious disease is unlikely. It is important to ask for a detailed description of the infant's birth history, significant past medical illnesses or injuries, feeding history, medications, history of known trauma, presence of vomiting and/or diarrhea, and immunization history.

### Physical Examination

A complete and thorough physical examination is essential. This exam should include completely undressing the infant and examining all parts of the body.

Skin findings can include uncomfortable rashes such as eczema or varicella, minor trauma, redness or swelling from an immunization reaction, or subtle findings of abuse.

Vital signs are important to note. Fever can be associated with a variety of infections, including viral illnesses, otitis media, urinary tract infection, or meningitis. Tachycardia might be indicative of blood loss from trauma, dehydration, stress reaction, congestive heart failure, or if  $>200$ , supraventricular tachycardia. Tachypnea can be associated with a variety of respiratory illnesses, hypoxia, or heart failure.

Potential findings in the ears, eyes, nose, and mouth include various foreign bodies, otitis media, infectious processes, and evidence of teething. Eyes should be examined with fluorescein to look for a corneal abrasion.

Respiratory findings, such as wheeze or rales, suggest a variety of respiratory-related illnesses, including asthma, bronchiolitis, pneumonia, foreign body, and congestive heart failure. The latter is further supported by auscultation of a significant murmur.

Abdominal findings, such as significant tenderness or guarding, are suggestive of potential surgical concerns usually requiring timely intervention. These include incarcerated hernia, volvulus, intussusception, and appendicitis. Gas-

troenteritis can present with irritability, but should be accompanied by other signs related to the gastrointestinal system (vomiting, diarrhea).

Findings on genitourinary examination may suggest testicular torsion. Hair tourniquet of a digit or penis is an uncommon cause of irritability which can only be discovered on careful examination.

Abnormal neurologic findings, including a markedly abnormal cry or specific neurologic signs, are suggestive of meningitis.

Lastly, the extremities should be examined for abnormal movement or tenderness, suggestive of trauma or an infectious process, such as osteomyelitis or septic arthritis.

The history and physical examination, taken together, often uncover the etiology of infant irritability. However, the clinician will still frequently be faced with a patient who has a negative evaluation.

The good news is that the majority of these infants will prove to be quite consolable by feeding or holding during or shortly after their evaluation. This group of infants is unlikely to have significant underlying illness, and is more likely to be exhibiting behavior related to the many non-urgent causes of irritability (Table 2).

### Colic

For the infant less than 3- to 4-months-old, a common diagnosis is either normal crying or infantile colic.

While a detailed discussion of colic is beyond the scope of this article, it is important to remember the basic definition of colic: unexplained paroxysms of irritability, fussing, or crying lasting for a total of more than three hours a day on more than three days per week. These “attacks” typically occur in the evenings, starting between 3-days and 3-weeks-of-age and subsiding by 3- to 4-months-of-age.

If the patient you are examining does not fall within these parameters, it is unlikely to be colic. Specifically, one needs to use caution in giving the diagnosis of colic in a young infant presenting with new-onset irritability.

**Table 2. Common Non-urgent Causes of Irritability**

Otitis media
Minor trauma
Viral syndrome with or without fever
Stomatitis
Immunization reactions
Minor skin rashes
Teething
Insect bites



## PEDIATRIC URGENT CARE

### Other Possibilities

For other infants, it is important to discuss the various possibilities with the caregivers. Issues concerning feeding (over- or underfeeding), teething, and parental stress related to infant care are all important to explore. Caregivers should be questioned about the options for increased support, such as family or friends, during this stressful period. Most importantly, since a definitive diagnosis has not been established, infants in this group should receive follow-up within 24 to 48 hours (or sooner, if indicated) to ensure that a more serious illness was not missed.

Occasionally, an infant will have a negative evaluation, yet will continue to be inconsolable during and after the evaluation. Although infants in this group may prove to have a benign underlying cause, a substantial number of infants in this category will ultimately prove to have a significant illness or injury.

In the truly inconsolable infant with a history of persistent irritability, it is prudent to consider some ancillary testing. At a minimum, electrolytes, CBC, urinalysis and urine culture, and lumbar puncture with evaluation/culture of the cerebrospinal fluid, should be considered.

Urinary tract infection has been found to be a significant cause of irritability in infants with a non-contributory history and physical examination.

Other tests to consider include skeletal survey and head CT scan (for trauma or abuse).

An infant with a negative laboratory and radiographic work-up who becomes consolable may be sent home with reliable parents and close follow-up, generally within 24 hours. Any infant who remains inconsolable is best admitted to the hospital until a diagnosis can be established.

### Conclusion

Although at times a simple diagnosis is easily established, the infant presenting with excessive irritability often presents a significant challenge. Establishment of the likely diagnosis, combined with exclusion of significant illness or injury, is a prerequisite to the formulation of an appropriate management plan.

Through a logical and stepwise approach, the urgent care clinician can usually establish the etiology and develop a treatment plan for infant irritability. When unable to determine the underlying cause for a particular infant, close follow-up should result in optimal patient care. ■

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# On Med Errors, Syncope in Older Patients, Pain with Cervical Strain, Low Back Pain, and Red Eye

■ NAHUM KOVALSKI, BSc, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

### Diagnostic Medical Errors: What Goes Wrong and Why

**Key point:** *Errors often occur because clinicians don't consider the diagnosis, test for it, or follow up on abnormal test results.*  
**Citation:** Schiff GD, Hasan O, Kim S, et al. Diagnostic error in medicine: Analysis of 583 physician-reported errors. *Arch Intern Med.* 2009;169:1881-1887.

Autopsy data from the past few decades reveal diagnostic error rates of 10% to 15%, but do not inform us about the causes of these errors. Absent extraordinary surveillance of the clinical process, only reporting by clinicians who have committed or observed errors can tell us about what goes wrong and why.

Researchers recruited U.S. physicians by mail and at meetings and asked them to anonymously report three cases of diagnostic errors (their own cases or those of close associates) and to fill out a questionnaire describing the error, the contributing factors, the seriousness of its clinical impact, and the correct diagnosis.

The steps in the diagnostic process that were most frequently associated with errors were laboratory and radiologic testing, accounting for 44% and 32% of errors, respectively.

Pulmonary embolus and drug reactions were the most frequently missed diagnoses (4.5% each), followed by lung can-

cer (3.9%), colorectal cancer (3.3%), breast cancer and acute coronary syndrome (3.1% each), and stroke (2.6%).

Seriousness of clinical impact was rated as major for 28% of errors, moderate for 41%, minor for 22%, and none for 6%; data were missing for 3%.

How to ensure that physicians always consider and rank the possible etiologies of their patients' symptoms remains vexing. A system of real-time, computer-driven data management that is embedded in physician workflow could go a long way toward meeting this goal.

[Published in *J Watch Emerg Med*, December 18, 2009—].  
Stephen Bohan, MD, MS, FACP, FACEP.] ■

### Can We Risk Stratify Older Patients with Syncope?

**Key point:** *A syncope score stratifies patients aged ≥60 into groups with low, intermediate, and high risk for serious events within 30 days.*

**Citation:** Sun BC, Derosé SF, Liang L-J, et al. Predictors of 30-day serious events in older patients with syncope. *Ann Emerg Med.* 2009;54(6):769-778.

Guidelines suggest that patients <60 years of age with no obvious cause of syncope or evidence of cardiac or electrocardiogram abnormalities can be treated as outpatients. Less evidence is available to guide management of syncope in patients aged ≥60, who have higher rates of syncope and associated serious events than younger patients.

In a retrospective chart review, researchers identified clinical variables that correlated with the occurrence of serious



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## ABSTRACTS

events within 30 days in 2,584 patients aged  $\geq 60$  who presented with syncope or near syncope without a serious underlying cause to three emergency departments in California during a four-year period.

Serious events included arrhythmia, hemorrhage or anemia, myocardial infarction, structural heart disease, stroke, pulmonary embolism, aortic dissection, subarachnoid hemorrhage, and death.

Variables associated with increased risk for serious events were age  $>90$ , male sex, history of arrhythmia, triage systolic blood pressure  $>160$  mm Hg, abnormal ECG result, and abnormal troponin I level. One variable—complaint of near syncope rather than syncope—was associated with lower risk.

The authors calculated risk scores by adding high-risk predictors and subtracting the low-risk predictor. A score of -1 or 0 correlated with an event rate of 2.5% (low risk); a score of 1 or 2 with an event rate of 6.3% (intermediate risk); and a score of 3 to 6 with an event rate of 20% (high risk).

[Published in *J Watch Emerg Med*, January 8, 2010—Richard D. Zane, MD, FAAEM.]■

### Muscle Relaxant Adds No Benefit to Ibuprofen for Cervical Strain

**Key point:** Pain relief did not differ among patients who received ibuprofen, cyclobenzaprine, or both drugs. Citation: Khwaja SM, Minnerop M, Singer AJ. Comparison of ibuprofen, cyclobenzaprine or both in patients with acute cervical strain: A randomized controlled trial. *CJEM*. 2010;12(1):39-44.

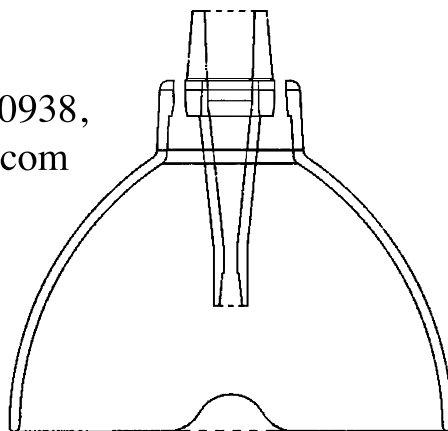
Muscle relaxants often are prescribed for neck and back pain, despite the lack of evidence of benefit. Researchers evaluated the effect

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of cyclobenzaprine in a prospective, randomized, double-blind study in a convenience sample of 61 adult patients (mean age, 34; 58% women) who presented to a level I trauma center emergency department with acute cervical strain.

Patients received ibuprofen (800 mg), cyclobenzaprine (5 mg), or both drugs three times daily for up to seven days, as needed for pain. All patients received an initial dose of 800 mg of ibuprofen in the ED.

Patients rated pain severity on a 100 mm visual analog scale 30 to 60 minutes after taking the morning dose of medication. Pain scores improved significantly over seven days in all three groups and did not differ among groups. Adverse effects were minimal.

A small dose of cyclobenzaprine was used in this study, perhaps to avoid the anticholinergic, antihistaminic, and sedative side effects of this drug, which is closely related chemically to tricyclic antidepressants.

No convincing evidence supports the use of cyclobenzaprine in painful musculoskeletal conditions, and the drug's benefit-to-adverse effect profile, therefore, argues against prescribing it.

[Published in *J Watch Emerg Med*, February 5, 2010—Kristi L. Koenig, MD, FACEP.] ■

## Low Back Pain and Best Practice Care: A Survey of General Practice Physicians

**Key point:** *Usual Care for Low Back Pain Doesn't Align with Guideline Recommendations*

**Citation:** Williams CM, Maher CG, Hancock MJ, et al. *Arch Intern Med*. 2010;170(3):271-277.

Researchers examined data on some 1,700 visits to general practitioners for new low back pain from 2005 to 2008, after national guidelines for treating musculoskeletal pain were released.

Among the findings: Although guidelines recommend acetaminophen as a first-line analgesic, it was prescribed for only 18% of patients. NSAIDs and opioids were prescribed for 37% and 20%, respectively. One fourth of patients were referred for imaging, despite guidelines advising against routine referral. Only one fifth of patients received advice and education as recommended.

The authors concluded that "the results indicate that in most cases, usual care is not evidence-based care and so is not likely to provide the best outcomes." ■

## Diagnosis and Management of Red Eye in Primary Care Reviewed

**Key point:** *Primary care physicians can handle/triage cases of red eye.*

**Citation:** Barclay L. Diagnosis and management of red eye in primary care reviewed.

Available at: [www.medscape.com/viewarticle/715549](http://www.medscape.com/viewarticle/715549).

Eye discharge, redness, pain, photophobia, itching, and visual changes are the characteristic signs and symptoms of red eye. The condition is usually benign and can be managed by primary care physicians. Conjunctivitis is the most common cause of red eye.

Other common causes of red eye conjunctivitis include blepharitis, corneal abrasion, foreign body, subconjunctival hemorrhage, keratitis, iritis, glaucoma, chemical burn, and scleritis.

Complete patient history and thorough eye examination are needed to diagnose the cause of red eye. Useful questions to cover in the history include duration of symptoms and whether they are unilateral or bilateral, type and amount of discharge, visual changes, pain severity, photophobia, response to previous treatments, use of contact lenses, and history of allergies or systemic illness.

Ocular examination should include thorough inspection of the eyelids, lacrimal sac, pupil size and reactivity to light, corneal involvement, and the pattern and location of hyperemia, as well as visual acuity and the presence or absence of preauricular lymph node involvement.

In viral conjunctivitis, vision, pupil size, and reaction to light are typically normal. Findings may include diffuse conjunctival injections (redness), preauricular lymphadenopathy, and a lymphoid follicle on the undersurface of the eyelid. Pain is usually mild or absent, but there may be occasional gritty discomfort with mild itching and watery to serous discharge.

Herpes zoster ophthalmicus is associated with a vesicular rash, keratitis, and uveitis. Rash and conjunctivitis usually precede the pain and tingling sensation in a dermatomal distribution, followed by periocular vesicles. Someone presenting with these symptoms should be referred to an ophthalmologist.

Acute and chronic bacterial conjunctivitis are associated with eyelid edema, conjunctival injection, mild to moderate pain with stinging foreign-body sensation, and mild to moderate purulent discharge. Visual acuity is usually preserved, with normal pupil reaction and no corneal involvement. The most predictive factor is the presence of mucopurulent secretions with bilateral glued eyes on awakening. *Staphylococcus aureus* is the most common pathogen in adults, and *Streptococcus pneumoniae* and nontypeable *Haemophilus influenzae* are most common in children.

The underlying cause of red eye determines the appropriate course of treatment. In the primary care management of red eye, a crucial objective is to recognize when emergent referral to an ophthalmologist is required.

Conditions mandating referral include severe pain refractory to topical anesthetics, need for topical steroids, vision loss, copious purulent discharge, corneal involvement, traumatic eye injury, recent ocular surgery, distorted pupil, herpes infection, or recurrent ocular infections. ■





## INSIGHTS IN IMAGES

# CLINICAL CHALLENGE: CASE 1

In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of dermatologic conditions that real urgent care patients have presented with.

If you would like to submit a case for consideration, please e-mail the relevant materials and presenting information to [editor@jucm.com](mailto:editor@jucm.com).

FIGURE 1

RT

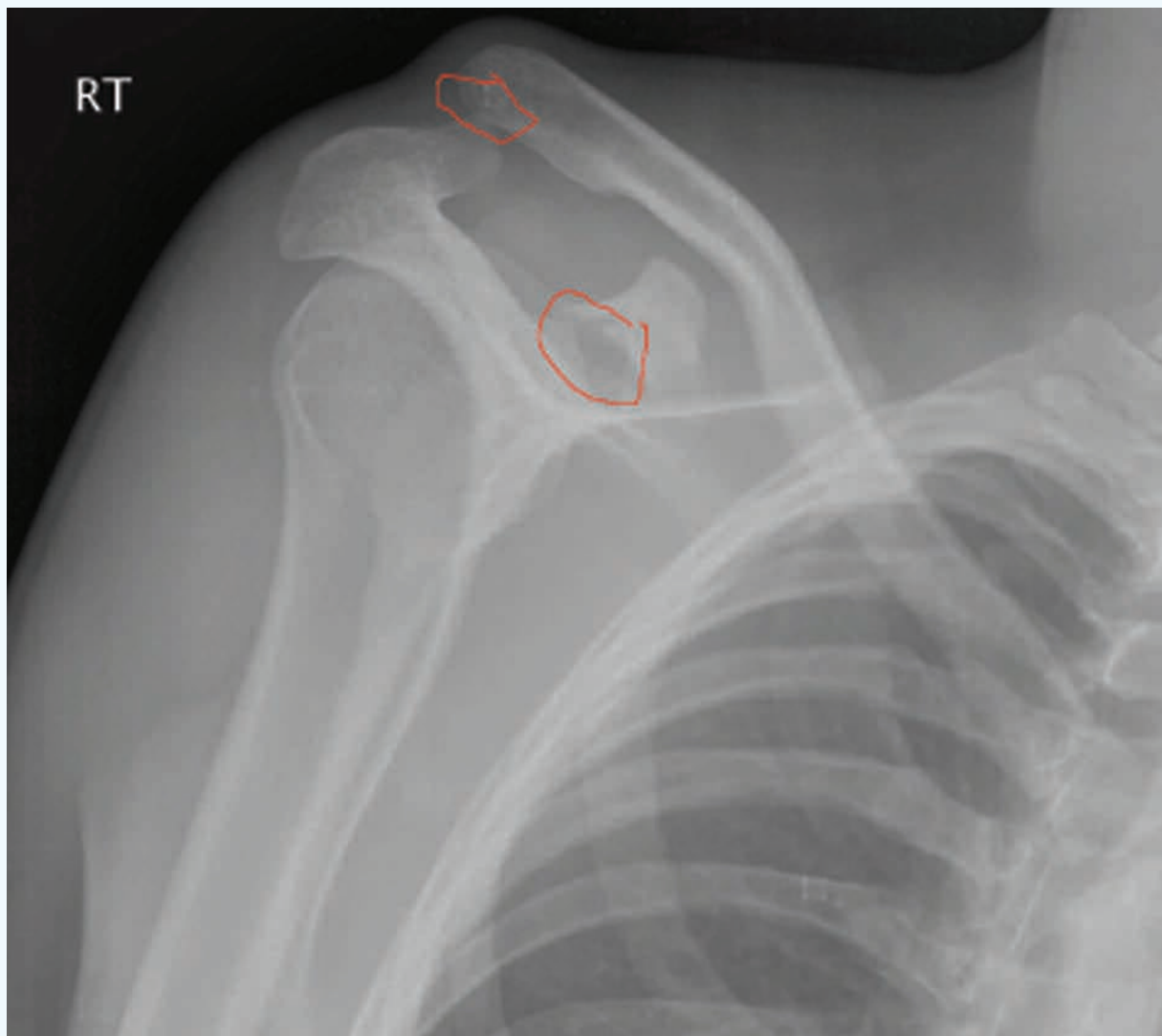


The patient is a 22-year-old male who fell and landed directly on his shoulder. On examination, you note marked local swelling and decreased range of motion.

View the image taken (**Figure 1**) and consider what your diagnosis and next steps would be.

Resolution of the case is described on the next page.

THE RESOLUTION



The x-ray shows a fracture of the coracoid process and a separation of the acromioclavicular joint.

This is a significant trauma, meriting evaluation by an orthopedist in the hospital.

*Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.*

*This case is one of hundreds that can be found in Terem's online X-ray Teaching File, with more being added daily. Free access to the file is available at <https://www2.teremi.com/xrayteach/>. A no-cost, brief registration is required.*



FIGURE 1



The patient is a 26-year-old who presents to urgent care after “twisting” the right foot, complaining of local pain but able to bear weight.

View the image taken (**Figure 1**) and consider what your diagnosis and next steps would be.

Resolution of the case is described on the next page.

THE RESOLUTION



The patient suffered a cortical avulsion fracture of the navicular bone. This injury is usually associated with ligamentous injury of the mid-foot.

Apply a posterior short leg splint and recommend orthopedic follow-up.

*Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.*



# Protecting the Urgent Care Center from Sexual Harassment Claims

**Urgent message:** Sexual harassment claims can be costly for an urgent care operator, not to mention ruinous to a center's reputation. An urgent care center should protect itself by having firm policies and procedures in place to prevent and resolve sexual harassment issues.

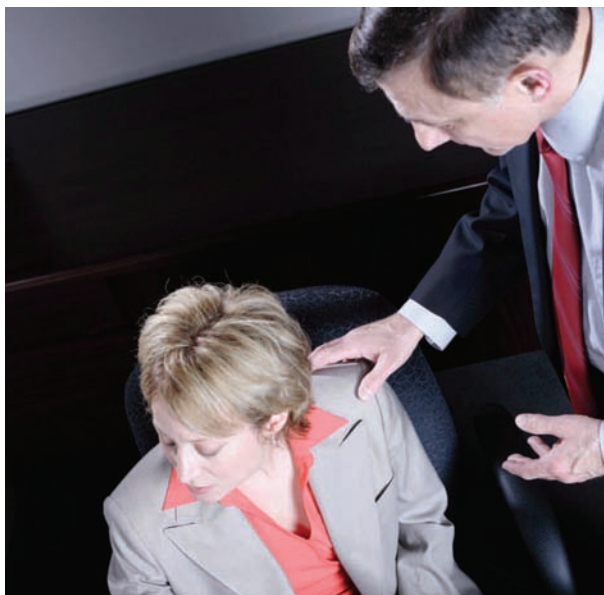
Alan Ayers, MA, MAcc

Sexual harassment emerged as a major human resources issue in the 1990s. Victims of alleged sexual harassment—who can be men or women—sometimes find sympathetic juries will award punitive damages and attorney fees amounting to thousands of dollars against a business owner—regardless of whether the owner engaged in, or was even aware of, the harassment.

To protect the business and maintain its reputation, an urgent care operator must create a workplace that is free of harassment and promptly deal with any allegations of inappropriate behavior.

### What is Sexual Harassment?

According to the U.S. Equal Employment Opportunity



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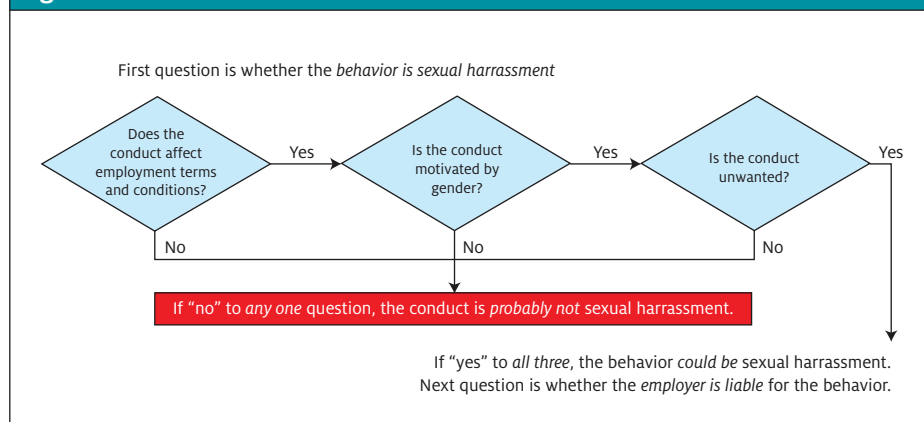
Commission, sexual harassment involves any unwelcome, one-sided, sexual advances; requests for sexual favors; and other verbal or physical conduct of a sexual nature that comes from supervisors, coworkers, clients, or other individuals in the workplace. It may be perpetrated by men, women, transgendered, or gender-confused persons; victims may be heterosexual or homosexual, and of the same or opposite sex as the perpetrator.

Sexual harassment violates federal and many state laws that prohibit discrimination, intimidation, retaliation,

and other conduct which undermines the integrity of the employment relationship.

Conventional definitions of sexual harassment divide behavior into one of two categories:

**Figure 1. Is the behavior sexual harassment?**



der. **Figure 1** illustrates this new framework for determining whether behavior is sexual harassment.

### Sexual Harassment Risks in Urgent Care Centers

Numerous factors (highlighted in **Table 1**) contribute to sexual harassment being a business risk for urgent care centers.

In physician-owned and operated businesses, providers and staff not only work long hours in close proximity, but

■ **Quid pro quo harassment:** When advancement of one's career—such as a promotion, pay raise, time off, or more desirable working conditions or hours—is dependent on providing sexual favors. Quid pro quo also applies to avoidance of a detriment, such as being fired or demoted. Usually, the victim has to choose between submitting to the harassment and losing his/her job. One occurrence is generally sufficient to prove quid pro quo harassment.

■ **Hostile and offensive work environment:** More common but also more difficult to prove than quid pro quo harassment is a hostile and offensive work environment where unwanted physical or verbal behavior interferes with an employee's work performance, or where an intimidating and offensive work setting is created. The frequency and severity of behavior contributing to a "hostile and offensive work environment" is subject to interpretation by the courts, but generally the harassing behavior is repeated over time.

Because some circumstances can be classified under both headings—and many instances of "sexual harassment" are neither "hostile" nor "sexual"—courts have moved away from the quid pro quo/hostile environment dichotomy to instead look at whether or not the terms and conditions of employment are affected because of unwanted conduct motivated by gen-

there are significant differences in power, income, and social status between the two. It's often easy for

**Table 1. Factors That Make Urgent Care Centers Susceptible to Sexual Harassment Claims**

- Typically, urgent care centers are small businesses; when the owner, operator, and supervisor are the same individual, an employee may feel they are unable to voice a complaint without their job being threatened.
- There are gender differences and a broad power differential between the medical doctor—who is typically the center's owner, operator, and/or employee supervisor—and support staff in terms of income, education, and social status.
- Providers and assistants working long hours in close proximity settings like labs and exam rooms may be conducive to unwelcome touching that could be considered harassment. In addition, medical practice often occurs behind closed doors with no witnesses.
- Urgent care centers deal with patient privacy related to sexual behavior and physical appearances on a daily basis. Comments to staff about a patient's sexuality or physical attributes outside the context of providing medical treatment may be considered offensive.
- There is greater diversity in the medical workforce, with changes in conventionally anticipated gender roles. Urgent care centers must be sensitive to unexpected patterns of harassment—initiated by men or women, heterosexuals or homosexuals, and targeting individuals of the same or opposite gender.
- Start-up medical practices often fail to conduct thorough reference and background checks. An individual who has been disciplined or dismissed from previous employment due to harassing behavior can bring a host of problems—including "negligent hiring" claims—to a future employer if such behavior is not anticipated and contained.

providers and staff to become too casual in their interactions and naïve as to the perceptions of certain behavior or the liability posed to the practice.

### When is an Urgent Care Center Liable for Sexual Harassment?

An urgent care center may be liable for the acts of its employees if an owner, officer, supervisor, or other individual with power over an employee engages in behavior that could be considered sexual harassment.

Likewise, an employer may be liable for creating a harassing environment if the employer:

- fails to take steps to prevent a hostile and offensive work environment
- fails to respond to specific complaints or allegations of harassment
- knows about potentially offensive behavior and fails to take corrective action.

**Table 2** illustrates situations in which an employer may be liable for harassment.

Urgent care centers have a duty to prevent and correct harassment, and employees have a duty to avoid harassment by using the center's complaint procedures. (Every urgent care center should have such procedures in place and known to employees, though further discussion of such is beyond the scope of this article.) However, many urgent care centers have not addressed the issue or have not defined a policy regarding sexual harassment.

### Urgent Care Centers Need a Sexual Harassment Policy

An urgent care operator's best defense is to make sure that everyone in the center—providers, administrators, supervisors, and staff—understands there will be zero tolerance of harassment in the workplace, that complaints may be taken “straight to the top,” that a timely, thorough, and impartial investigation of any claims will occur, and that appropriate and swift corrective action will be taken based on the findings.

A written sexual harassment policy, included in the employee handbook, can avert much of the risk of sexual harassment by providing instructions for employees and managers when sexual harassment issues arise. Common elements of a written sexual harassment policy are outlined in **Table 3**.

**Table 2. Is the employer liable for harassing behavior?**

<i>If the harasser is a(n):</i>	<i>then the employer is liable when</i>	<i>unless the employer can show</i>
Owner Manager Stockholder CEO President	harassment occurs.	NA
Supervisor	harassment occurs and results in a negative employment action.	NA
Supervisor	harassment occurs and causes a hostile working environment	<ul style="list-style-type: none"> <li>• employer took reasonable steps to prevent and quickly stop harassing behavior <i>and</i></li> <li>• employee unreasonably failed to take advantage of employer's efforts to prevent or stop harassing behavior or to avoid harm.</li> </ul>
Coworker	employer knew or should have known about the harassment	employer took immediate and appropriate corrective action.
Non-employees (e.g. patient, office tenant, vendor)	employer knew or should have known about the harassment	employer took immediate and appropriate corrective action.
NA, not applicable.		

In addition, an urgent care center's general policies and procedures should address sexual harassment issues specific to the urgent care operating model.

For instance, urgent care centers deal with a whole host of patient contact issues. Any jokes or unnecessary comments about a patient's physical appearance or sexual behaviors should be strictly off limits. A provider must also be aware of the potential for patients to create or engage in potentially hostile situations or advances towards staff, and implement policies that protect staff members. These include:

- A chaperone, most likely a staff member or someone the patient arrived with, of the patient's gen-

**Table 3. Common Elements of a Sexual Harassment Policy**

*The urgent care operator's duty to prevent sexual harassment starts with developing a strong policy statement and disseminating it to all employees:*

- **Adopt an attitude of zero tolerance.** A sexual harassment policy should make it clear there are serious consequences to sexual harassment and that employees should avoid all behaviors that cast coworkers in sexual terms or have the potential of being offensive or intimidating.
- **Define sexual harassment and provide examples.** The policy should define what sexual harassment is and include examples of intolerable behavior, such as comments about an employee's body or clothing, sex-based jokes or innuendo, gossip and rumors about an employee's personal life, dating or asking employees out, sexual assault or inappropriate touching, and others.
- **Develop a complaint procedure.** Employees who feel they've been harassed should understand their duty to report it timely and accurately, using the employer's complaint procedure. The policy should outline every step of how to file a complaint, how an investigation will occur, and how outcomes will be reported, as well as punitive actions that may be taken.
- **Document every incident.** With a process in place, employers should document every alleged incident—regardless of how seemingly minor—and maintain detailed notes of every step taken in resolution. Failure to document and investigate a claim can be held against an employer at a later date, even if it's found no harassment occurred.
- **Assure confidentiality and anti-retaliation.** All parties to a sexual harassment claim can be embarrassed, and allegations—regardless of whether they're substantiated—can permanently damage reputations. Except when necessary for an investigation or legal action, all communication around a sexual harassment claim should be kept strictly confidential.  
Because sexual harassment is typically a power move of a supervisor over a subordinate, those who have been subjected to harassment must also know they will have protection against later vengeful acts. Retaliation against someone who has complained about sexual harassment is against the law.
- **Implement an ongoing training program.** Having a sexual harassment policy is not enough; the policy must be accompanied by an active and ongoing training program. The policy should, therefore, describe how it is communicated to employees, including the content and frequency of training.

Sources: Schickman MI. Sexual harassment: Employer's role in prevention. *American Bar Association General Practice, Solo & Small Firm Practice Guide*. 1996; Winter. Schleifer J. 8 elements your sexual harassment policy must have...and why just having a strong policy isn't enough. *HR Daily Advisor*. 2006; June 18. Hartmus D. Elements of a good sexual harassment policy. *The Public Manager*. 2000; Spring. Reese L. Employee satisfaction with sexual harassment policies. *Public Personnel Management*. 2004; March 22.

der should always be present when a doctor is examining a patient of the opposite sex.

- The provider should document in the patient's chart who was present during the examination, to prevent from relying on memory should an issue arise at a future date.

Every complaint, no matter how seemingly trivial or easily resolved, should be documented and investigated according to the written policy.

### **Creating a Process for Documenting and Investigating Claims**

As with any clinical issue that leads to litigation, thorough written documentation is the employer's best defense should a sexual harassment claim progress to a lawsuit.

The employer's response to complaints, the level of detail involved in conducting investigations, and punitive consequences should be applied consistently across cases to avoid "double standards" in which a favored employee receives a "slap on the wrist" versus a more negative outcome in another case. Not only is being fair and equitable an important component of preventing and correcting harassment, but efforts to intimidate or retaliate against an employee who has filed a claim can result in damages—even if it turns out no sexual harassment occurred.

The individual receiving and investigating claims should never be a supervisor or in the chain of command of the alleged harasser or victim, but rather, an independent or neutral third party—such a human resources officer or board advisor. Small businesses where the owner, operator and supervisor are the same individually typically refer complaints to their attorney and utilize an experienced consultant to conduct the investigation.

Any employee found to have participated in sexual harassment that is still with the organization after punitive action is taken should be monitored to assure the employee has completely disengaged from such behavior.

### **Assuring a Harassment-free Culture**

Urgent care operators have a duty to provide

*Continued on page 35*





## Too Big to Fail—Urgent Care Lessons from Toyota

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

In his book *How the Mighty Fall: And Why Some Companies Never Give In*, Jim Collins discusses the five markers or stages of decline and how a company can identify these stages and reverse itself even after large-scale defeats along the way. (Or, as Bluto (John Belushi) said in *Animal House*, “Was it over when the Germans bombed Pearl Harbor?”)

Applying those stages to the rough patch of road Toyota has been riding brings into focus a cautionary tale with applications to many other industries—including urgent care.

### Stage 1: Hubris Born of Success

Arrogance or hubris kicks in when leaders believe that they are entitled to their success because they are so (fill in the adjective) smart/hardworking/innovative/disciplined, etc.

Toyota had enjoyed a 20-plus year history as *the* quality automotive leader. Essentially, they were wedded to their own success story. The company realized too late that its vehicles had serious safety issues because their collective ego, built upon 20 years of success, could not accept that they, too, suffered from engineering missteps.

The most successful businesspeople I know remain both humble and irrationally afraid that their success is only due to luck or some other fortuitous circumstances that were somehow out of their control. They continue to devote their energies towards constant improvement and always believe their competitors are on their heels.

Take-home point: As Frank Leahy, the venerable Notre Dame football coach once said, “Egotism is the anesthetic that dulls the pain of stupidity.”

### Stage 2: Undisciplined Pursuit of ‘More’

*Undisciplined* means that business leaders are delving into

new unexplored areas or are pursuing areas outside of their core values without adequately assessing their risks.

If you believe that you can accomplish anything given your past success, this headlong race to the unknown is the logical next step. This has also been called growth for growth’s sake, or overreaching.

Until about five years ago, Toyota spread its best engineers out all over the world in its new plants or design studios to mentor young engineers. That stopped when they dramatically increased their production capacity and did not have enough of their seasoned engineers to go around. Despite the fact they had large cash reserves, they did not have the necessary fuel (human capital) to grow their infrastructure.

Take-home point: Your growth cannot outpace your talent.

### Stage 3: Denial of Risk and Peril

Discounting data which portend bad results is the hallmark of stage 3. Leaders fall back on their egos and explain away bad results as temporary or cyclical, never looking at the root-cause of the issue. At the same time, leaders put a positive spin on neutral data and over emphasize good data.

In the case of Toyota, executives admitted that they had purposely underplayed the disparate reports of unexplained acceleration.

Think of it this way: If you are a fighter pilot flying an airplane, you consciously make some decisions and take some risks which will subject your plane to some hits. However, if you take a risk that can, if it fails, blow your wing off, you will want to take a hard look at whether the risk outweighs the benefit.

As Pappy Boyington, leader of the Black Sheep Squadron said, “The air battle is not necessarily won at the time of the battle. The winner may have been determined by the amount of time, energy, thought and training an individual has previously accomplished in an effort to increase his ability as a fighter pilot.”

*Continued on page 34*



**John Shufeldt** is the founder of the Shufeldt Law Firm, as well as the chief executive officer of NextCare, Inc., and sits on the Editorial Board of *JUCM*. He may be contacted at [JJS@shufeldtlaw.com](mailto:JJS@shufeldtlaw.com).



# Selling Wellness Services to Employers

■ FRANK H. LEONE, MBA, MPH

Somewhere between the episodic nature of the typical urgent care visit and the steady relationship between patient and primary provider lies a need for employers—your occupational medicine customers and prospects—to support the health of their employees.

This need may be especially great with many companies having trimmed their workforces; fewer employees doing more work than ever before means there is real economic value in keeping those workers well and on the job.

Given that instilling proper health habits serves to enhance the health status of a worker population, thereby reducing unnecessary costs for a parent company, wellness services might seem like an “easy sell.” Nothing could be further from the truth.

Consider the following:

- Historically, wellness services have been offered in a standalone, a la carte manner, along the lines of a weight management lecture, or an isolated smoking cessation program. Yet experts caution against wellness interventions that are not developed in the larger context of an integrated, long-term and systematic approach.
- Services have rarely been designed around the genuine needs of the worker population at a given company. Granted, Health Risk Appraisals have been out there for decades, but they were rarely done in conjunction with a wellness program and, when conducted, the connection between the results of an HRA and an ensuing intervention strategy has been spotty at best.
- Wellness services have seldom been marketed (rather than sold), and many clinics’ employer prospect uni-

verses were poorly educated about wellness services. Wellness services, standalone commodities that they were, invariably sat at the bottom of most sales professionals’ portfolios.

- Generally, it has proved difficult to articulate the value of a wellness program. The typical approach was simply to recite such buzz phrases as: “lowers cost,” “increases productivity,” “lowers absenteeism.” On the rare occasions when actual data were rolled out to support these platitudes, the information tended to be confusing and/or meaningless to the employer prospect.

### The New Wellness Sales Paradigm

In the hope that we have learned from our mistakes, I offer six principles that support the new wellness services sales paradigm:

1. **Make each wellness package needs based.** Make wellness programs responsive to the genuine needs of a company’s workforce. This is where HRA assessment tools come in. A superior tool provides a roadmap to identify high-risk individuals, associate unhealthy health habits with an approximation of lost dollars, and serves as the foundation for a multistage wellness intervention strategy.  
But it does not end there. Far too often, the results from an assessment instrument are not interpreted, are interpreted poorly, and/or do not lead to a prudent intervention strategy.
2. **Anoint “wellness services” with a new moniker.** Wellness sales professionals are often victims of the errors associated with selling wellness services in the past. Often, prospective buyers recoil at the mere mention of the term “wellness.” Try not to enter the battle with one arm tied behind your back. Come up with a synonym that suggests a refreshingly new, modern intervention, such as “employee health enhancement.”
3. **Recognize that marketing drives sales.** Ideally, marketing drives sales, not vice versa. The probability of success

*Continued on page 35*



**Frank Leone** is president and CEO of RYAN Associates and executive director of the National Association of Occupational Health Professionals. Mr. Leone is the author of numerous sales and marketing texts and periodicals, and has considerable experience training medical professionals on sales and marketing techniques. E-mail him at [fleone@naohp.com](mailto:fleone@naohp.com).



# Coding X-Rays Ordered by Outside Docs, G-code for Drug Testing, and 99051 for Scheduled Visits

■ DAVID STERN, MD, CPC

**Q.** We have quite a few primary care physicians who regularly send patients to our urgent care center for x-rays. These patients have a prescription for the x-ray service, and they don't want to be seen by the urgent care doctor.

I have several questions related to this service:

1. Should we collect the urgent care copay (or) radiology imaging services copay (which is usually \$0)?
2. Should we code S9083 to payors whose contract states that the only contract we may bill is the urgent care global code—S99083?
3. Should we add S9088 (services rendered in an urgent care center)?
4. Should I use the same diagnosis code that the patient brings along with the script from their primary care doc for billing purposes?
5. The urgent care physician does not see the patient face-to-face, but is the physician still responsible to read the x-ray?

— Question submitted by John Whalen, Aloma Urgent Care, Florida

**A.** In answer to your questions:

1. **Copay:** Every payor is different, so you will have to check with each payor. Since you are contracted as an urgent care, payors may automatically apply the urgent care copay. You may, however, be able to get payors to waive this

copay when only radiological services are performed. Contact each payor to understand their policy.

2. **S9083:** Most payors may accept this code, especially since they usually have no way to see that no physician services were rendered by the urgent care center. The payor, however, is not likely to view this as the intended use of the code. Just billing the x-ray codes without having the payor change your setup is likely to result in denials.

Since their software is likely designed to allow only this code from your practice, you should contact the payor to see if they will allow you to bill radiological services, when this is the only type of service provided.

Some payors may refuse to pay for visits for radiological services only, as they will interpret the contract as offering reimbursement for urgent care services only. But with persistence on your part, most payors will be reasonable in finding a way to reimburse you for this important service to their members.

3. **S9088:** Payors may reimburse you for this code, though doing so would not be consistent with the spirit of this code for this type of visit, as you are not actually rendering urgent care services. Such coding abuses often result in payors changing their policies and result in blanket denials for certain codes, even for urgent care centers that are using the codes as they were intended to be used.
4. **ICD-9:** Yes, the diagnosis on the prescription is appropriate to use. You will want to be sure that the payor will cover the specific radiological service (i.e., reimburse for the CPT) when linked to that ICD-9 code.
5. **Professional fee:** Usually, the urgent care center will send these films to an outside radiologist, who will provide a reading back to the ordering physician and bill the appropriate CPT code with modifier -26 (professional component) to get reimbursed for the reading of the study. In



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this arrangement, you would code the CPT code with modifier –TC (technical component) to be reimbursed for the actual shooting of the film. ■

**Q. Is it appropriate to use special after-hours coding (99051), if the appointment was scheduled prior to the date of service?**

– Question submitted by Annette Richardson, Mayo Hospital, ME

**A.** This coding method may fit into the strict definition of the code, but it does not seem to fit the intent of the rules. Payors that reimburse this for this code typically intend to reimburse urgent care centers for the additional expense of offering an alternative to the ED on evenings, weekends, and holidays. Payors are not generally intending to reimburse a practice simply for scheduling convenient hours for simple physician office visits.

You could check with each payor, but as a general rule I would discourage this practice, as abuses such as these tend to result in blanket changes of payor policies that end up being applied to practices that do code as intended by the payor for these codes. ■

**Q. We offer pain management services, and we have started drug testing all patients upon their visit to our clinic. We are trying to bill Medicare for an E/M and a drug screen, using code G0431. The explanation for the denial is that the provider is not certified or eligible to be paid from this service. We have a CLIA number attached to the claim.**

– Question submitted by Tammy Scott

**A.** This question illustrates how complicated coding can be and how cryptic explanations of denial can be. The code G0431 became effective on January 1, 2010. Until April 1, 2010, however, CMS has instructed providers with a CLIA certificate of waiver to report CPT 80101QW. All other laboratory providers must report G0431. You may need to re-bill any claims for service dates between January 1 and March 31, 2010. ■

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Or as Warren Buffet says, “It is only when the tide goes out that you learn who has been swimming naked.” Around now, Toyota President Akio Toyoda is looking for his suit.

**Stage 4: Grasping for Salvation**

By the time the decline is finally recognized, leaders typically respond one of two ways. When a leader ties their hopes and the company’s fortune on a radical transformation, a new product, an untested strategy, or some other sweeping game-changer, they have stepped into Stage 4.

Conversely, when they return to their core values and culture, when they make deliberate, thoughtful choices only then can they start back on the road to recovery.

To Toyota’s credit, much of their public statements have focused on repairing their brand and returning to their quality roots. Toyota, like many other companies facing huge challenges (Xerox, HP, etc.), has experienced many months of a downward spiral. Making a rapid course reversal will not happen overnight, and will only come about with a deliberate, focused strategy.

**Stage 5: Rolling Over and Dying**

Everyone knows someone who, when the going gets tough, simply “folds up the tent.” In stage 5, after repeated “silver-bullet” failures and false starts, the company’s finances and *esprit de corps* are so marginalized that the management team gives up hope and simply settles for surviving or dying.

The point of their struggle should not be to simply survive, but to persevere and regain their leadership position. This requires leaders who keep the faith and never, despite every setback, give up.

One of my favorite quotes on this subject is from Calvin Coolidge, who said, “Nothing in this world can take the place of persistence. Talent will not; nothing is more common than unsuccessful people with talent. Genius will not; unrewarded genius is almost a proverb. Education will not; the world is full of educated derelicts. Persistence and determination alone are omnipotent. The slogan ‘press on’ has solved and always will solve the problems of the human race.”

I suspect that Toyota will not be grasping for salvation; nor will they roll over and die. It is more likely that they will return to their roots, redesign their production system, take their lumps from the various members of Congress, and regain their dominance.

Great companies are not made or lost overnight. Thankfully, the warning signs which portend collapse are, according to Jim Collins, fairly consistent and are reversible if the business’s leaders remain focused on their core values and dedicated to persevering. ■



on a given sales call goes up immeasurably if the prospect is familiar with your organization, products, and the inherent value of these products.

Update prospective buyers on the value and associated return-on-investment of packaged wellness services. There is rarely enough time in a sales call to walk a prospect through such concepts. Thus, a wellness initiative begins by steadily educating your public. Think sound bites, testimonials, and the sharing of national success stories.

4. **Reflect your prospect's perspective.** When a sales professional is selling a conceptual product, the inherent reaction is to spout forth a litany of features and rationale. Just the opposite is advisable.

Instead, use questions to understand the prospect's vantage point and encourage them to share their perspective. Useful questions might include:

- "How does your absenteeism compare with your expectations?"
- "Overall, how do you rate the overall health of your employees on a scale of 1 to 5?"

5. **Offer a taste test.** I recently sampled a tiny chunk of cheese at our local supermarket. Going in, I had not planned to buy that or any other cheese; yet based on the sample, I purchased an entire chunk.

So it is with a discretionary purchase such as wellness services.

Consider, for example, offering a discrete service—say, a weight management program for up to five employees at each of 20 target companies. Granted, this is not the long-term plan, but decision makers tend to notice and participants tend to return to their workplace as strong and vocal advocates of your program.

6. **Educate.** The more intangible a product is, the more you need to become an educator and less a salesperson. Rather than "you should," or "I suggest," extend phrases such as "the data show," or "it is recognized within the healthcare community that a fully integrated approach to health and safety generates the most significant long-term result to a company's health and safety."

As of this writing, we are dealing with an uncertain national economy; better to bring it up, face it, and use it to your advantage than to ignore it. A compelling argument might be:

"In today's economy, with a leaner company staff and company resources, the well being of every one of your employees becomes even more important. Your company's prosperity is contingent on sending the healthiest, most positive team out there to the playing field each and every day." ■

## *Sexual harassment training should be mandatory, and employees should confirm they understand the policy.*

a workplace that's free of intimidation and harassment; this starts with a culture where employees treat with each other with mutual respect, interact on a professional plane, and know to not even test the "gray areas" of inappropriate behavior. Consistent enforcement of policies that define unacceptable behavior and outline the consequences of "crossing the line" is an important starting point for prevention.

However, it's not enough to simply adopt and publish a sexual harassment policy; the urgent care operator must also communicate the philosophy and procedures associated with the policy to everyone in the center.

One way to do this is to set a date each year in which the policy will be delivered to every employee. Training should describe what the policy contains, provide examples of what constitutes unacceptable behavior, and outline the process for making a complaint. Sexual harassment training should be mandatory, and employees should sign a form confirming that they have received and understand the policy. Records of training dates, attendance, and content should be maintained in case it becomes necessary to prove the center is taking appropriate preventive steps.

### Conclusion

Sexual harassment is a human resources reality that can jeopardize the finances and reputation of an urgent care center. However, urgent care operators can fulfill their duties to limit the risks associated with sexual harassment by developing policies prohibiting such behaviors in the workplace, outlining a procedure for investigating and resolving complaints, and communicating to staff through recurring training programs.■

*Disclaimer: Sexual harassment is a complex legal issue. Please note that while the author offers practical management advice for the urgent care operator, he is not an attorney and his recommendations are not to be construed as legal advice. Always seek competent legal counsel before acting.*



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For more information or to submit your CV for consideration, please contact Andrea Henson, Physician Recruiter at 540-224-5241 or [ahenson@carilionclinic.org](mailto:ahenson@carilionclinic.org).



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, located in Florence, South Carolina is seeking a BC/BE FM physician to work in our Urgent Care facility. The facility's hours of operation are Monday-Friday 8:00AM-8:00PM and Weekends 9:00AM-4:00PM. The physicians work on average of 72 hours every 2 weeks with every other weekend off.

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McLeod is dedicated to patient-centered, evidence-based, and physician-lead health care. This is an opportunity where not only can you practice medicine, but also live a balanced and fulfilled lifestyle. For more information, please contact Angela Stukes, Physician Recruitment (843) 777-5169, [astukes@mcleodhealth.org](mailto:astukes@mcleodhealth.org) or visit our web site at [www.mcleodphysicianrecruiting.org](http://www.mcleodphysicianrecruiting.org)

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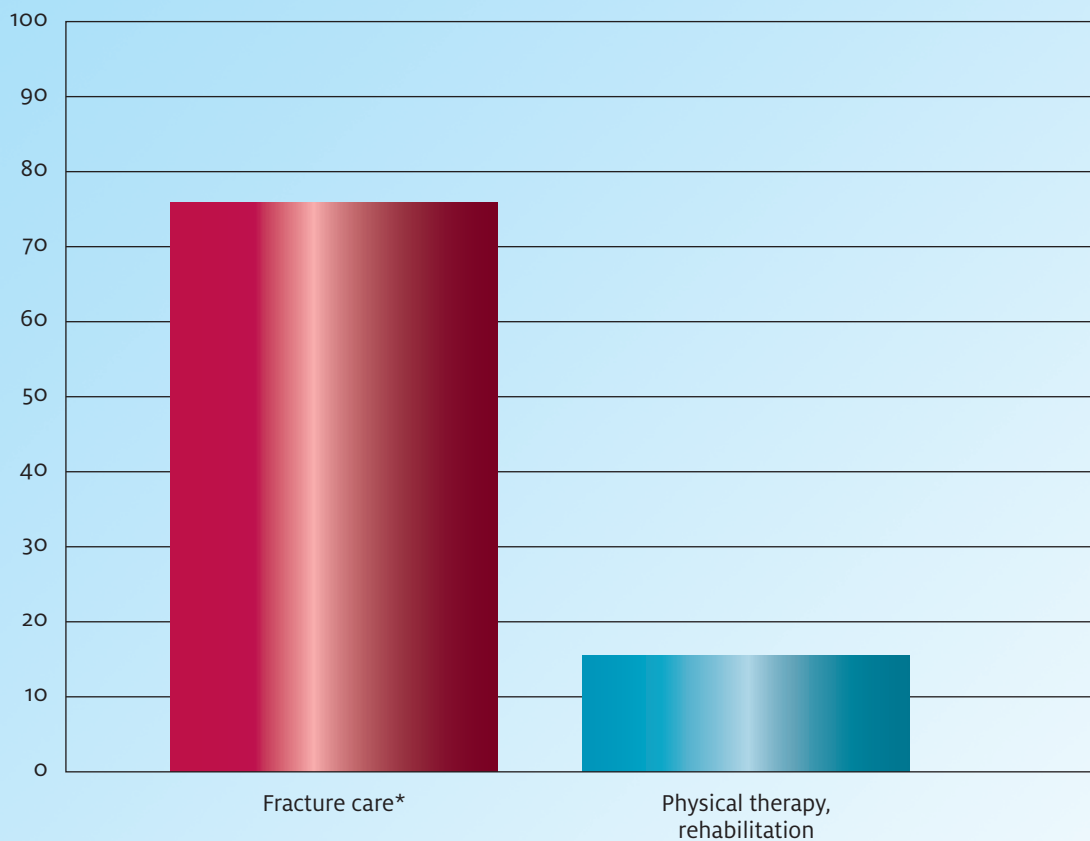
## DEVELOPING DATA

In early 2008, UCAOA revamped its annual survey in conjunction with researchers at Massachusetts General Hospital and Harvard University with the goal of assuring that the UCAOA Benchmarking Committee's efforts produced a scientifically valid report.

Here, we present some of the data from this landmark survey.

*In this issue:* What orthopedic-related services do urgent care centers tend to offer?

### ORTHOPEDIC-RELATED SERVICES



*\*"Fracture care" includes splinting and casting.*

The question regarding orthopedic-related services was just one segment of a section of questions on services offered in urgent care centers. Future Developing Data pages will offer insight into lab tests processed and other diagnostic tests performed on site.

Acknowledgment: Data submitted by Robin M. Weinick, PhD, at the time of the survey assistant professor, Harvard Medical School and senior scientist, Institute for Health Policy, Massachusetts General Hospital. Dr. Weinick is also a member of the *JUCM* Advisory Board. Financial support for this study was provided by UCAOA.

If you are aware of new data that you've found useful in your practice, let us know via e-mail to [editor@jucm.com](mailto:editor@jucm.com). We'll share your discovery with your colleagues in an upcoming issue of *JUCM*.



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