

JUCM™

THE JOURNAL OF URGENT CARE MEDICINE®

DECEMBER 2010
VOLUME 5, NUMBER 3

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

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Cold Weather- related Injuries

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LETTER FROM THE EDITOR-IN-CHIEF

Funding Healthcare Reform: Tax Sugar, Not Success



Healthcare is the ultimate paradox for democratic and capitalist ideals, an epic clash between inalienable rights and free market forces. Most everyone agrees that basic healthcare should be attainable, affordable, and non-discriminatory for all citizens. But how can we achieve this somewhat socialist-sounding goal within a free market system?

Well, the free market has proven incapable of making healthcare affordable, and government coffers have proven too empty to subsidize it. At some point, we will need to abandon either the goal of universal healthcare or the embrace of capitalism as universally anti-tax.

So, if we must tax our way to universal healthcare, how we go about it is the next challenge.

Let's look broadly at how the current plan hopes to pay for healthcare reform:

- Tax the "rich."
- Tax the industry.
- Improve efficiency.

It seems that the political strategy du jour is to tax the rich. This strategy has proven politically safe for several reasons: It impacts approximately 1% of the population; it is an income tax, so the impact is on individuals, not large corporations or interest groups; and it is considered palatable to the general public, which has little sympathy for the wealthy class. So what's the big deal?

A tax on the "rich," as it is currently proposed, is inherently "anti-productivity." The concept is essentially a tax on *success*, discouraging investment and efficiency. Additionally, a tax on the so-called "rich" is extremely punitive to physicians, who are being asked to carry more and more of the burden for healthcare reform as it is. More regulation, lower reimbursement, expanded Medicaid, astronomic education costs, and larger workloads. All under a cloud of medical liability.

Is it really fair to further punish a physician making \$200,000 per year? When you consider money invested in medical education and our delayed entry into the workforce—our earning years start relatively late by virtue of the time we spend in medical school and training—one could certainly argue whether or not this is even "rich."

Additionally, do we really want to further discourage our best

and brightest from choosing careers in medicine, particularly primary care medicine?

Is government, vis-à-vis the public, abusing the good faith of physicians for political convenience and expediency? I sure think so.

It is worth noting that individuals with incomes over \$200,000 are hardly "one class." Perhaps a new income class within a class should be considered (say \$200,000-\$500,000). The majority of earners in this range are professionals and small business owners.

Small business success is most often fleeting, with erratic income, good years and bad. Additionally, they are the most important hiring force in our fragile economy. It just doesn't make sense to penalize them.

The professional class has literally mortgaged their future "wealth" with the aforementioned cost of education and late entry into the workforce. With the cost of education skyrocketing, the only hope for a return on that investment rests on higher wages during the earning years. Doesn't make sense to penalize them, either.

Perhaps an added tax on high earners is necessary, but let's be careful not to overburden the professionals and small businesses.

Finally, most economists agree that taxing productivity is anti-stimulus. Yet, nearly everyone agrees that some new taxes will be necessary to reduce deficits and fund reform.

Taxing consumption is an enviable alternative on multiple levels. It is this author's opinion that America's economy has shifted from investment to overconsumption, and that tax policy could be used to restore balance.

In my next column, I will explore opportunities to tax overconsumption, reward investment, reduce healthcare costs, and encourage a healthier nation.

Look out "sugar," I'm coming after ya'. ■

Lee A. Resnick, MD
Editor-in-Chief

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Strep and Flu... Why Test?

"Rest and drink plenty of fluids" — the age-old prescription for common respiratory infections. But definitively diagnosing these infections can be a challenge. "The clinical symptoms of influenza tend to overlap with the symptoms of other respiratory infections in both pediatric and adult patients. This makes the clinical diagnosis of influenza problematic."*

"A rapid test that enables the early recognition of patients with influenza has many advantages":

- Prevent unnecessary antibiotic prescriptions, hospitalizations and Influenza transmission
- Contribute in the reduction of the economic burden of influenza
- Enable the proper use of antiviral agents

Healthcare professionals do have a choice. **Test your patients for Strep A and Influenza.** Better patient care...that's awesome, yes osom.



The Bottom Line

- ✓ Respiratory infections have similar symptoms
- ✓ Differential diagnosis leads to proper treatment and reduces healthcare costs
- ✓ Rapid tests provide tremendous value at the point-of-care

SYMPTOMS OF FIVE COMMON INFECTIONS/ RESPIRATORY ILLNESSES**	Influenza	Strep A	Meningitis	Whooping Cough	Pneumonia
Runny Nose / Sneezing / Congestion	✓			✓	
Fever	✓	✓	✓	✓	✓
Headache	✓	✓	✓		
Aches / Stiff Neck	✓	✓	✓		
Sore Throat / Cough	✓	✓		✓	✓
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* Theocharis, George. Vouloumanou, Evridiki et al. "Evaluation of a direct test for seasonal influenza in outpatients", *European Journal of Internal Medicine*, Vol.21 (2010) 434-438

** CDC Disease Listing, <http://www.cdc.gov/ncidod/dbmd/diseaseinfo/default.htm>

December 2010

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CLINICAL

11 Cold Weather-related Injuries

As the weather outside turns frightful in most of the country, urgent care providers must be vigilant for signs of hypothermia, frostbite, frostnip, and other seasonal conditions.

By Kosta G. Skandamis, MD

CASE REPORT

18 A 23-year-old Woman with Scapular Fracture



A patient who initially thought she escaped falling from a moving vehicle with nothing more than road rash finds herself in increasing pain as the days pass by. Taking a thorough history and ordering the appropriate imaging are key to accurate diagnosis.

By Shannon Dowler, MD

PRACTICE MANAGEMENT

28 Bridging the Management Divide: Understanding Physician Leadership



The gap between clinical expertise and the requirements of running a business may be most glaring in the entrepreneurial world of urgent care medicine.

By Trevor Rohm, MD, MS

IN THE NEXT ISSUE OF JUCM

Chest pain always presents a diagnostic challenge, whether in the outpatient family medicine setting or the hospital emergency room. Urgent care centers are no exception—and they're becoming more frequent destinations for patients with such complaints. Familiarity with the emergent causes may help in the development of chest pain protocols in urgent care.

WEB EXCLUSIVE

Stye—or Chalazion?

Ocular pathologies can be distressing to patients, even if the eventual diagnosis is relatively benign. It is essential for all acute care physicians to be comfortable evaluating the eye and to differentiate among conditions that need immediate referral and those that can be treated on site. Available only at www.jucm.com.

By Eric Langerman, Colleen Czerniak, Mikayla Spangler, PharmD, Shailendra Saxena, MD, PhD

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Case Western Reserve University
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JUCM The Journal of Urgent Care Medicine (www.jucm.com) is published through a partnership between Braveheart Publishing (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).

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EDITOR-IN-CHIEF

Lee A. Resnick, MD
editor@jucm.com

EDITOR

J. Harris Fleming, Jr.
[hj Fleming@jucm.com](mailto:hjfleming@jucm.com)

CONTRIBUTING EDITORS

Nahum Kovalski, BSc, MDCM
Frank Leone, MBA, MPH
John Shufeldt, MD, JD, MBA, FACEP
David Stern, MD, CPC

ART DIRECTOR

Tom DePrenda
tdeprenda@jucm.com



65 North Franklin Turnpike, Second Floor,
Ramsey NJ 07446

PUBLISHERS

Peter Murphy
pmurphy@braveheart-group.com
(201) 529-4020

Stuart Williams
swilliams@braveheart-group.com
(201) 529-4004

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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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JUCM, the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

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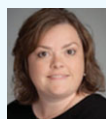
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That little nip in the air most of the country feels in early December will turn decidedly more biting—and dangerous—as the weeks wear on. By New Year's Day, urgent care centers can expect to see more patients who've spent too much time out in the cold, possibly unprepared for the conditions. For some of those patients, a little passive re-warming should do the trick. For others, though, life and limb may be in peril; some may even require emergent referral.

In Cold Weather-related Injuries (page 11), **Kosta G. Skandamis, MD** reviews the key symptoms, assessments, and treatments for hypothermia, how to distinguish between (and treat) frostbite and frostnip, and distinguishing characteristics and management strategies for other seasonal conditions.



Dr. Skandamis has traveled a circuitous clinical path on his way to practicing as an urgent care physician. He began his career as an OB/GYN in Toledo, OH before opting for some "retraining" in the art of family medicine at the University of Louisville. He migrated to the urgent care arena some six years ago, but still has a particular interest in women's health issues, as well as skin disorders.



Most injuries know no seasonal boundaries, of course. Patient's who've fallen from even slow-moving vehicles, for example, can expect to find themselves in need of medical care regardless of the temperature. Such is the case of A 23-year-old Woman with Scapular Fracture (page 18), a new report by **Shannon Dowler, MD**.

Dr. Dowler is medical director of Blue Ridge Community Health Services in Hendersonville, NC and, effective this month, vice president of the North Carolina Academy of Family Physicians. She also serves as a regional representative on the Buncombe County (NC) Medical Society Foundation board.

Some physicians may be more comfortable treating patients like these than filling the role of manager/boss/administrator. They've had extensive training to manage the array of illness and injury that walks through the door of the typical urgent care center; comparatively few have been to business school or had any formal leadership training. And yet, running an urgent care center demands expertise in both.

This dichotomy is the subject of Bridging the Management Divide: Understanding Physician Leadership (page 28) by **Trevor Rohm, MD**.



Dr. Rohm lives in Rio Rancho, New Mexico and is board-certified in family practice. He works as an urgent care physician for Presbyterian Healthcare Services. Prior to his endeavors into the world of medicine, he worked as a software engineer for a number of years for companies such as IBM, Waterford Institute, and MyComputer.com. He received his medical training and education at St. George's University and the University of New Mexico. He is actively involved in the

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American Academy of Family Physicians, American Medical Informatics Association, and the International Information Management Association, a business organization.

Finally, exclusively for www.jucm.com, medical student **Eric Langerman** and pharmacy student **Colleen Czerniak** have collaborated with **Mikayla Spangler, PharmD** and **Shailendra Saxena, MD, PhD** to share the case of a 50-year-old woman who presented with a three- to four-day history of eyelid swelling, pain, and redness with no history of trauma, discharge, or change in vision. The key question: Is it a sty or something more ominous, perhaps a chalazion? Read the article and find out.

Dr. Spangler is an assistant professor in the Department of Pharmacy Practice; Dr. Saxena is an assistant professor in the Department of Family Medicine. All are affiliated with Creighton University Medical Center in Omaha, NE.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews new abstracts on stroke prevention in patients who have already survived a stroke or transient ischemic attack, prevention of stroke in atrial fibrillation, whether lung imaging is helpful in diagnosing pulmonary embolism, and a clinical report on concussion in children.

John Shufeldt, MD, JD, MBA, FACEP explains how staying out of a “delta uniform” can help you stay out of court (hint: it has nothing to do with what a flight crew wears).

Frank Leone, MBA, MPH advocates for realistic aspirations and disciplined follow-through when creating a marketing plan for your occupational medicine services.

David Stern, MD, CPC responds to queries on complicated or multiple I&D, head CT, and follow-ups—and when to use CPT 99051

If you have a perspective to share, or an idea for an article, let us know. Send an email to our editor-in-chief, **Lee A. Resnick, MD**, at editor@jucm.com. ■

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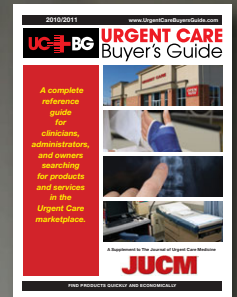


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FROM THE EXECUTIVE DIRECTOR

Looking Forward, Looking Back

■ LOU ELLEN HORWITZ, MA

ately, it seems like time flies whether you're having fun or not. Can it possibly already be December? 2010 was more like a bullet train than a roller coaster; most of the time we were all going too fast to know if we were really climbing up a hill or careening down.

For many in our country, however, it feels like they got kicked off the train and are standing in a lonely field watching it fly by without them. It's hard to say who's got it worse.

Practically every call we take these days from the media or from investors looking into urgent care includes the same question: "What effect do you think healthcare reform is going to have on the urgent care industry?"

To speculate would be futile. What we do know is this: regardless of the changes that take place between now and the day we start truly feeling the effects of whatever healthcare reform turns out to be, it's probably going to mean more patients seeking care. More patients without primary care physicians. More patients unused to "the healthcare system."

A significant unknown is, of course, what the payment structure for all of those patients is going to look like.

Have you started a dialogue within your centers about how you could manage more patients? Are you looking at ways to more efficiently manage your patient flow? Do you have a good recruiting system in place now for adding more providers as you need them? Do you have a good relationship with your local banker, in case you need cash quickly to expand your operations? Do you have a good records management system with room to grow and absorb a significant increase? Would now be a good time to look at all of your contracts with payors as you consider your strategies? Does it look like the bullet train has no likelihood of slowing down in 2011?

Actually, there will probably be a bit of a lull here for a few months. Washington has to "re-sort" itself from a staffing standpoint as different offices (both physical and nominal) change

"Do some examination of where you are and where you want to be."

hands and colors and everyone has to get back up to speed. Take advantage of that time between panic waves (!) to do some examination of where you are and where you want to be—and what you will need to do in the next year to get there.

As tumultuous as it has been out there, I hope that some of the things we've been doing at UCAOA have positively impacted you (or will in the future). As we have matured as an organization, we are seeing that our projects are getting bigger and having longer time horizons, so I use a lot of the space in these columns to talk about what is coming vs. what is past.

Here's a brief look back at a few highlights from 2010:

- UConnect launches. Our new "members only" area, full of easy-access resources and new ways to connect with your urgent care colleagues.
- Convention and conferences stay strong. The industry (and industry supporters) continues to come together for in-person meetings, defying trends across the association industry.
- Online education expands. We've done a complete overhaul of our online education, making it easier to access and a more robust educational experience.
- Corporate Support Partners stay supportive. Bucking trends across the country, our vendor partners continue to support UCAOA—and by extension, the urgent care industry.
- Fellowship programs grow. We added another Fellowship program this year, and there are more on the way.

In January, we'll pull back the curtain on the new programs we've been alluding to for months. (Some hints: a Foundation, a new "sister" organization, a new website for patients, benchmarking results, and more.)

See you in 2011—and remember, although it's moving fast, it's a great train to be on! ■



Lou Ellen Horwitz is executive director of the Urgent Care Association of America. She may be contacted at lhorwitz@ucaoa.org.

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Cold Weather-related Injuries

Urgent message: Inadequate protection from the cold can put a patient's life and limb at risk. The urgent care clinician must be able to identify symptoms of specific conditions, using the history and awareness of weather conditions to distinguish among the most common.

Kosta G. Skandamis, MD

Introduction

Winter months provide ample opportunities for recreation such as skiing, sledding, or snowmobiling—and for an array of injuries related to varying degrees of exposure to lower temperatures.

Generally, the extent of such injuries is related to duration of exposure and temperature, with factors such as wet clothing or high wind increasing the risk for more severe injury. The clinician should bear in mind, however, that patients are at risk even when temperatures are above freezing (32° F or 0° C), especially if they lack the proper gear and protection.

This article will review the level and type of injury most likely to present in the urgent care setting. We will concentrate on hypothermia—a dangerous drop in core body temperature—and injuries to body tissue, which can be divided in two categories: those that occur with the freezing of the body tissue (frostbite), and



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other milder forms that occur without freezing of the body tissue (e.g., frost-nip, pernio, and immersion foot or trench foot).

Hypothermia

Hypothermia is defined as a core body temperature below 35° C (95° F). It can be accidental or intentional and can be further classified as:

1. *mild*: 32° to 35° C
2. *moderate*: 28° to 32° C
3. *severe*: <28° C.

Though seen most often in areas where severe winters are more common, hypothermia is also seen in the southern United State.¹ Moderate to severe accidental hypothermia can be lethal in 40% of cases.²

Pathophysiology

Body *heat* is generated by cellular metabolism and is lost by skin and lungs; body *temperature* reflects the balance between heat production and heat loss. In response to cold stress, the hypothalamus stimulates

Differential Diagnosis for Hypothermia

- Ischemic or hemorrhagic stroke
- Alcohol toxicity
- Barbiturate overdose
- Hypoglycemia
- Ventricular tachycardia
- Ventricular fibrillation

heat production by shivering and by increasing thyroid and adrenal activity.

Hypothermia causes cellular membrane dysfunction and electrolyte imbalance (namely, hyperkalemia). Crystallization of intracellular and extracellular water leads to cell death.

Clinical presentation

The key to proper diagnosis and treatment of hypothermia is the determination of true core temperature. Practically speaking, this may not be feasible outside of a hospital ED; once initial evaluation utilizing a low-reading oral or rectal thermometer and proper stabilization and initial re-warming are complete, prompt transportation to the nearest hospital is advisable.

In addition to distinctions in core body temperature as mentioned previously, the clinician can gauge the severity of a patient's hypothermia according to certain characteristics of the clinical presentation.

A patient with *mild hypothermia* presents with tachypnea, tachycardia, hyperventilation, ataxia, and/or shivering.

Moderate hypothermia is characterized by:

- proportionate decrease in heart rate, cardiac output
- hypoventilation
- central nervous system depression
- hyporeflexia
- decreased renal blood flow
- decreased shivering
- and, finally, cardiac arrhythmias.

Severe hypothermia can lead to pulmonary edema, oliguria, hypotension, coma, ventricular fibrillation, and asystole.

Children are more prone to hypothermia due to small body mass and limited glycogen storage. In addition, young infants are unable to increase heat by shivering; as such, the clinician should not assume the parents' description of symptoms they've witnessed in children of that age group represents the whole story.

The elderly are also at increased risk for hypother-

mia due to decreased reserve, chronic illnesses, medications that can affect compensatory response, and possible dementia or isolation.

The clinician should bear in mind that certain medications (e.g., antidepressants, opioids, antipsychotics, ethanol, and general anesthetic agents) can cause hypothermia, either directly or indirectly.

In addition, blood pressure medications (e.g., beta-blockers, alpha-adrenergic agonists) can impair thermoregulation.

Assessment and management

The hypothermic patient should be handled gently; otherwise, arrhythmias may occur.

An airway should be established, and breathing and circulation should be maintained, in patients in respiratory distress or patients with altered mental status who cannot protect their airway.

The patient should be covered with warm, dry blankets.

Any complications should be addressed, and re-warming should be initiated.

Re-warming can be either passive external (for mild hypothermia), or active external, for moderate hypothermia (e.g., warm dry blankets, heating pads, radiant heat, warm baths). The trunk should be re-warmed before the extremities to avoid hypotension.

For severe hypothermia, active internal re-warming should be initiated alone or in combination. This includes warm (40° to 42° C) IV crystalloid, warm humidified O₂, and irrigation of body cavities with warm crystalloid.

Initial labs should include:

- finger stick blood sugar
- ECG
- BMP
- CBC
- ABGs
- drug screen.

Besides arrhythmias, hypothermia may cause characteristic changes in respiratory rate, pulse rate, QRS prolongation, and elevation of the J point (which produces the characteristic J or Osborn wave; **Figure 1**).³ The height of the Osborn wave is proportionate to degree of hypothermia.⁴

Remember, a low normal hematocrit is *abnormal* in severe hypothermia because hematocrit increases by 2% for every 1° C drop in temperature.

Also, insulin is ineffective below 30° C.

Hypothermia has neuroprotective effects, so complete recovery of patients with hypothermia and car-

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Table 1. Categorizing and Managing Hypothermia

Severity	Characteristics	Action
Mild	<ol style="list-style-type: none"> 1. Core body temp 32° to 35° C 2. Tachypnea 3. Tachycardia 4. Hyperventilation 5. Ataxia 6. Shivering 	Passive, external re-warming
Moderate	<ol style="list-style-type: none"> 1. Core body temp 28° to 32° C 2. Proportionate decrease in heart rate and cardiac output 3. Hypoventilation 4. Central nervous system depression 5. Hyporeflexia 6. Decreased renal blood flow 7. Decreased shivering 8. Cardiac arrhythmias 	Active external re-warming: <ul style="list-style-type: none"> • warm dry blankets • heating pads • radiant heat • warm baths
Severe	<ol style="list-style-type: none"> 1. Core body temp <28° C 2. Pulmonary edema 3. Oliguria 4. Hypotension 5. Coma 6. Ventricular fibrillation 7. Asystole 	Active internal re-warming (alone or in combination): <ul style="list-style-type: none"> • warm (40° to 42° C) IV crystalloid • warm humidified O₂ • irrigation of body cavities with warm crystalloid
For all hypothermic patients: <ul style="list-style-type: none"> • Handle gently to prevent arrhythmias from occurring. • Establish an airway; maintain breathing and circulation. • Be aggressive with fluids. • Cover with warm, dry blankets. • Address complications and re-warm; the trunk should be re-warmed before the extremities to avoid hypotension. 		

diac arrest has been well documented.⁵ Therefore, under usual circumstances, resuscitative efforts should be continued indefinitely until core temperature reaches 32° to 35° C (93° to 95° F).

Frostbite

When tissue is exposed to subfreezing temperature, ice crystals form both intracellularly and extracellularly, ultimately leading to cell death. Inflammation and ischemia also develop, which leads to further tissue necrosis.

Frostbites can be divided according to their severity in similar fashion to burns:

1. First degree: Central pallor, numbness of skin, surrounded by edema.
2. Second degree: Formation of vesicles with clear or whitish fluid, surrounded by edema and erythema.

3. Third degree: Deeper injury, hemorrhagic vesicles progress to black eschars over few weeks.

4. Fourth degree: Deeper injury extending to muscle and bone.

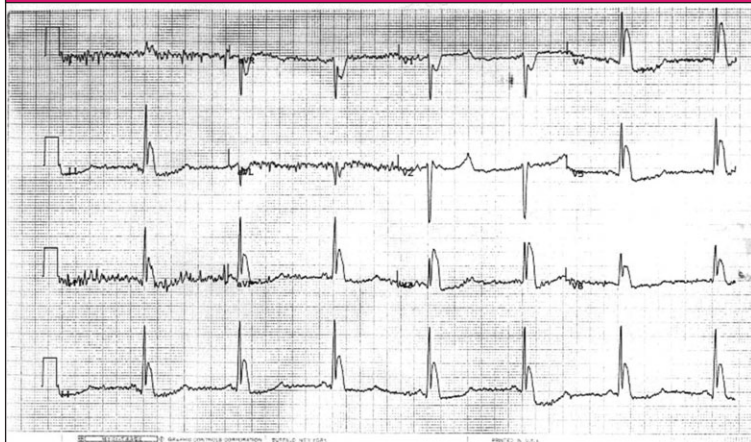
Risk factors

Any factor that increases heat loss or decreases heat production can lead to frostbite. Prime examples would be exposure to extreme cold, windy conditions, or prolonged contact with cold metal or water.⁶

Exhaustion, malnutrition, diabetes, mental illness, alcohol consumption, and tobacco abuse (by virtue of associated peripheral vascular disease) are all factors that increase risk of frostbite.⁷

Young children, the elderly, women, and African-Americans are at higher risk for frostbite.⁸

As noted earlier, the clinician should also be cog-

Figure 1.

nizant of the fact that exposure to cold weather is not the only causative factor for frostbite; e.g., accidental frostbite has been reported after prolonged application of ice packs without a buffer between skin and the ice pack in musculoskeletal injuries.⁹

Clinical presentation

Hands, feet, and face are the most frequently affected sites of frostbite.¹⁰ Depending on the depth of the injury at the time of evaluation, the patient may present with symptoms ranging from just pallor and numbness to blood-filled blisters, eschars, and tissue necrosis.

Treatment

The role of the urgent care provider as described here is assumed to be at the pre-hospital level, either at the site of the injury or at an outpatient establishment.

First and foremost, the patient should be removed from the cold place, given dry, warm clothes, and covered with warm, dry blankets.

If there is a chance of refreezing, do not re-warm frostbite, as this worsens tissue injury.

Handle the frostbitten area with care; pad or splint extremities.

Do not unroof small blisters; maintain aseptic technique; avoid occlusive dressings and only use non-adherent gauze.

Large bullae that interfere with movements can be drained and bandaged.

Advise the patient to avoid using frostbitten extremities, and to never rub or massage frostbitten areas.

Passive external re-warming can be initiated by placing the extremity in warm water or using body heat, by placing hands in the axillae.

Tetanus prophylaxis is indicated if the patient is not up to date.¹¹

Topical antibiotics are not indicated, but parenteral antibiotics should be given in case of infection. Prophylactic antibiotics

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At its core, JUCM, *The Journal of Urgent Care Medicine* is a forum for the exchange of ideas and a vehicle to expand on the core competencies of urgent care medicine.

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Physicians, physician assistants, and nurse practitioners are invited to submit cases, including x-rays, EKGs, or photographic displays relating to an interesting case encountered in the urgent care environment. Submissions should follow the format presented on the preceding pages.

If you have an interesting case to share, please e-mail the relevant images and clinical information to editor@jucm.com. We will credit all whose submissions are accepted for publication.

JUCM
THE JOURNAL OF URGENT CARE MEDICINE

COLD WEATHER-RELATED INJURIES

are controversial, but are indicated at the first symptoms of infection and should cover *Pseudomonas*, *Strep* and *Staph*.

The presence of hypothermia should be considered.

Complications

Infection and gangrene formation with amputation are the short-term complications of frostbite. Long-term complications include paresthesias and decreased sensation of the frostbitten areas.

Early surgical consultation is recommended, as frostbite may require long-term wound care.

Prevention

The most commonly suggested ways to avoid frostbite include:

1. limiting the time of exposure to cold weather
2. dressing in layers
3. covering face, eyes, ears and hands
4. wearing warm, waterproof boots
5. avoiding tobacco and alcohol
6. maintaining adequate fluid intake
7. refraining from applying emollients to exposed skin.¹²

In addition, when a trip to the wilderness is planned, adequate preparation should be made. Proper supplies should be gathered, and immediate family should be notified of the planned duration and anticipated route for the trip.

Other Cold-weather Injuries

In addition to the urgent or emergent conditions described previously, there are several relatively common, less-severe injuries that nonetheless require assessment (even if only to rule out the more serious frostbite). These include:

Frostnip

The term “frostnip” refers to a milder form of cold-related injury to the tissue. There is no deep tissue freezing involved, nor permanent damage present; the main characteristic is reversible blanching of the skin, typically on the earlobes, cheeks, nose, fingers, and toes.

Frostnip can develop several hours after exposure to extreme cold. The primary complaint is likely to be local paresthesias that resolve quickly with re-warming.

Pernio or chilblain

This is a common type of cold weather-related injury, again without tissue freezing. Toes, fingers, ears, and

nose are the most often affected parts.

The affected areas are itchy, painful, edematous, and red or purple. In some cases, blisters or small ulcers may also form.

Pernio usually last for several days and heals completely after several weeks.

Trench foot

First described during World War I, trench foot is caused by prolonged immersion in cold water or mud (hence its alternate name, "immersion foot"), causing alternating arterial vasospasm and vasodilation. Tight boots exacerbate the condition.

Initially, the feet become cold and anesthetic. After 24 to 48 hours, hyperemia follows and feet become red-hot with a burning sensation, and are edematous and painful. Often, hemorrhagic bullae and ulcers are formed.

Following this, the post-hyperemic phase occurs after two to six weeks. The limbs become cyanotic and sensitive to cold. Cellulitis, lymphangitis, and gangrene may develop.

Better knowledge about the condition, improved foot hygiene, better boot design, and keeping feet dry has almost eliminated the condition among our troops. The homeless, on the other hand, are still susceptible.

Referral Criteria

The extent of the injuries, the overall patient condition, and the capabilities of the urgent care center and its providers will determine the necessity for and timing of referral to the ED. ■

References

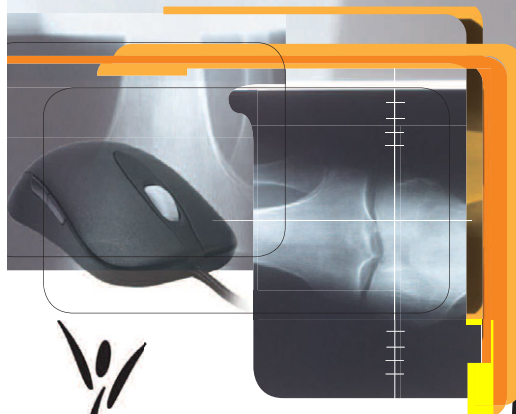
1. Burke WP. A case report of warm weather accidental hypothermia. *J Miss State Med Assoc.* 2004;45(9):263-266.
2. Vassal T, Benoit-Gonin B, Carrat F, et al. Severe accidental hypothermia treated in ICU: prognosis and outcome. *Chest.* 2001;120(6):1998-2003.
3. Nolan J, Soar J. Images in resuscitation: The ECG in hypothermia. *Resuscitation.* 2005;64(2):133-134.
4. Graham CA, McNaughton GW, Wyatt, JP. The electrocardiogram in hypothermia. *Wilderness Environ Med.* 2001;12(4):232-235.
5. Gilbert M, Busund R, Skagseth A, et al. Resuscitation from accidental hypothermia of 13.7°C with circulatory arrest. *Lancet.* 2000;355(9201):375-376.
6. Geng Q, Holmér I, Hartog DE, et al. Temperature limit values for touching cold surfaces with the fingertip. *Ann Occup Hyg.* 2006;50(8):851-862.
7. Rintamaki H. Predisposing factors and prevention of frostbite. *Int J Circumpolar Health.* 2000;59(2):114-121.
8. DeGroot DW, Castellani JW, Williams JO, et al. Epidemiology of U.S. Army cold weather injuries, 1980-1999. *Aviat Space Environ Med.* 2003;74(5):564-570.
9. Graham CA, Stevenson J. Frozen chips: an unusual cause of frostbite injury. *Br J Sports Med.* 2000;34(5):382-383.
10. Ervasti O, Juopperi K, Kettunen P, et al. The occurrence of frostbite and its risk factors in young men. *Int J Circumpolar Health.* 2004;63(1):71-80.
11. Chan TY, Smedley FH. Tetanus complicating frostbite. *Injury.* 1990;21(4):245.
12. Lehmuskallio E. Emollients in the prevention of frostbite. *Int J Circumpolar Health.* 2000;59:122-130.

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Case Report

A 23-year-old Woman with a Scapular Fracture

Urgent message: Mechanism of injury—in this case being thrown from a slow-moving vehicle—provides essential clues to the extent of injuries, even if the patient initially thought them to be relatively minor. Proper evaluation requires a thorough history.

Shannon Dowler, MD

The Case

The patient is a 23-year-old female who presented to urgent care with an approximately 36-hour history of “shoulder pain.” She is otherwise well-appearing.

Discussion with the patient reveals that she was riding as a passenger in a Jeep with the doors off when she took her seatbelt off as they rounded the final curve to her garage. She fell out of the jeep onto the ground while the car was still moving, reportedly at approximately 10 miles per hour.

The patient reports that she fell onto her left side and that her only injuries—or so she thought at the time—was some “road burn” along her left arm and shoulder.

She did not seek medical attention at the time.

The patient went to bed that night and woke up “sore” the next day. Her pain persisted throughout the day, through the time she was encountered in the exam room, 36 hours after being thrown from the vehicle.



Observations and Findings

Evaluation of the patient revealed the following:

PMH: No chronic illnesses and no history of fractures

Meds: Oral contraceptives

Allergies: None

FH: Noncontributory

SH: Alcohol was involved in the accident, but the patient was not driving.

– Nonsmoker.

– Student.

– No recreational drugs.

ROS: Complaining of pain with lifting her left shoulder “in front” and “on the side.” Denies any

head trauma. Denies any chance of pregnancy. No cough, chest pain, or shortness of breath. Essentially negative ROS except for upper extremity pain.

PE: T: 98.7; BP: 126/80; HR: 79; RR: 16

Gen: Pleasant, well-appearing young female in no acute distress; alert and oriented x3

Ext: Superficial abrasions noted on forearm and over deltoid area without signs of infection; exam of shoulder reveals no bony deformity and no focal

Figure 1.



Figure 2.



Figure 3.



Figure 3.



bony tenderness to palpation though discomfort over AC joint and lateral deltoid; no neurologic or vascular deficits; active ROM markedly diminished but passive ROM reveals 50% extension and abduction limited due to pain

CV: NSR without m/r/g

Pulm: CTAB without w/r/r

X-rays: See figures

Diagnosis

The patient has a non-displaced fracture through the body of the scapula. Confirmation with CT revealed “non-displaced vertically oriented fracture of the scapula involving the body of the scapula, scapular spine and supraspinatus portion of the scapula.”

There was no evidence of glenoid fossa, acromion, or coracoid process involvement; the AC joint was intact.

No visualized associated humerus or rib fractures seen.

Discussion

Scapular fractures are usually associated with significant traumas, most typically resulting from motor vehicle injuries and pedestrian-MV injuries. The clini-

cian should be alert to other associated injuries (e.g., clavicle, rib, spine, pulmonary, abdominal injuries).

If the patient is stable and has no other associated injuries and pain can be controlled on an outpatient basis, shoulder immobilization and narcotic analgesia with referral to orthopedics on an outpatient basis is a reasonable approach to management.

CT scan is generally recommended to assess for degree of displacement because surgical fixation is indicated with >1 cm medial displacement or >40° angulation. ■

Make Your Case

If you enjoyed or learned something from this case report, consider returning the favor by sending us one of your own. We're always looking for interesting cases to share with the urgent care community.

This one is a good example of what we're looking for. If you're unsure how to get started, however, tell us a little about the case and we'll help you get started.

Address submissions or inquiries to: editor@jucm.com.

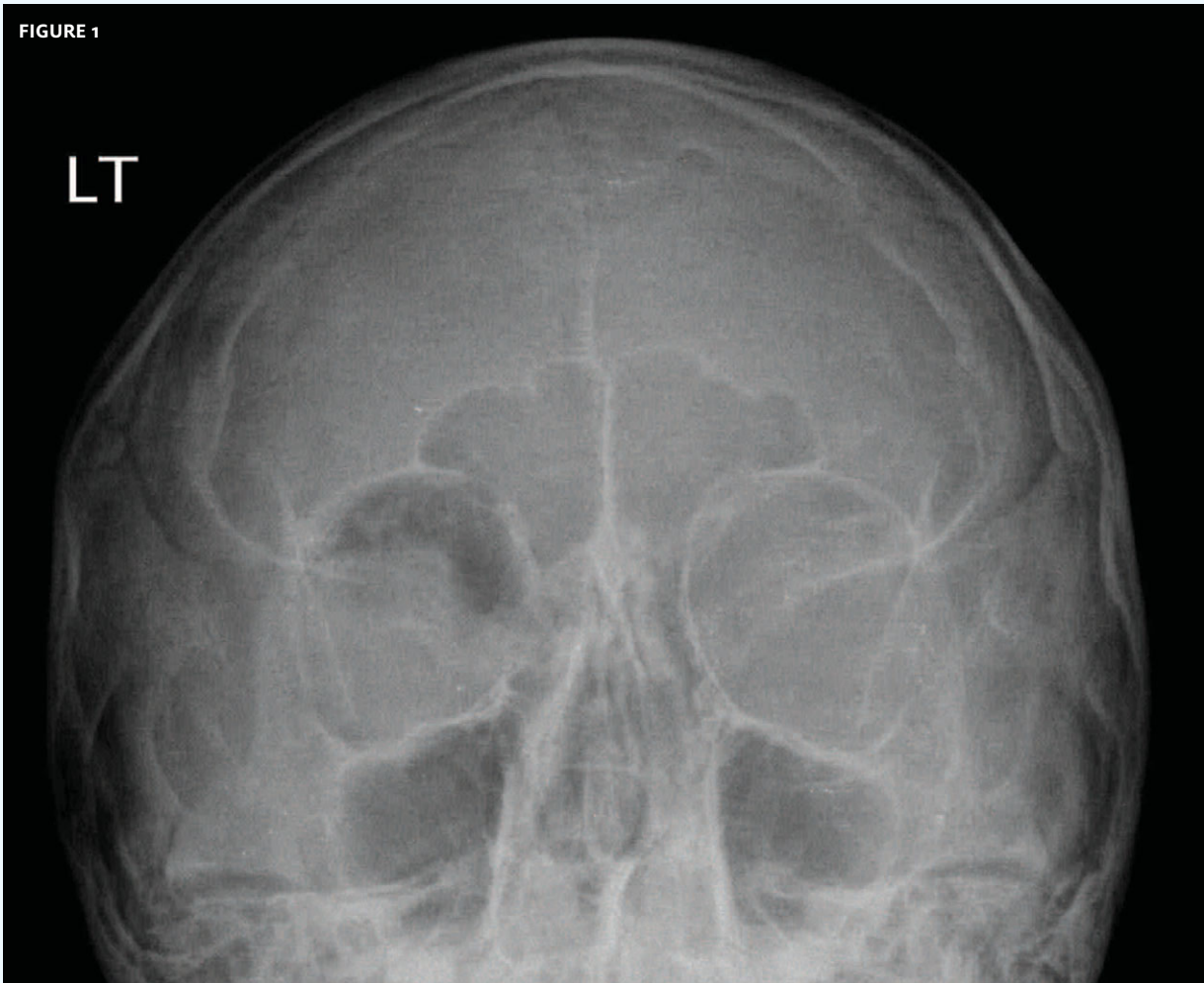
We look forward to hearing from you, and to sharing your experiences and expertise with colleagues.



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 email the relevant materials and presenting information to editor@jucm.com.

FIGURE 1



The patient is a 16-year-old boy who presents with local swelling of both eyelids. There is no limitation in the range of motion of either eye, however.

The patient reports that the swelling occurred immediately after he blew his nose.

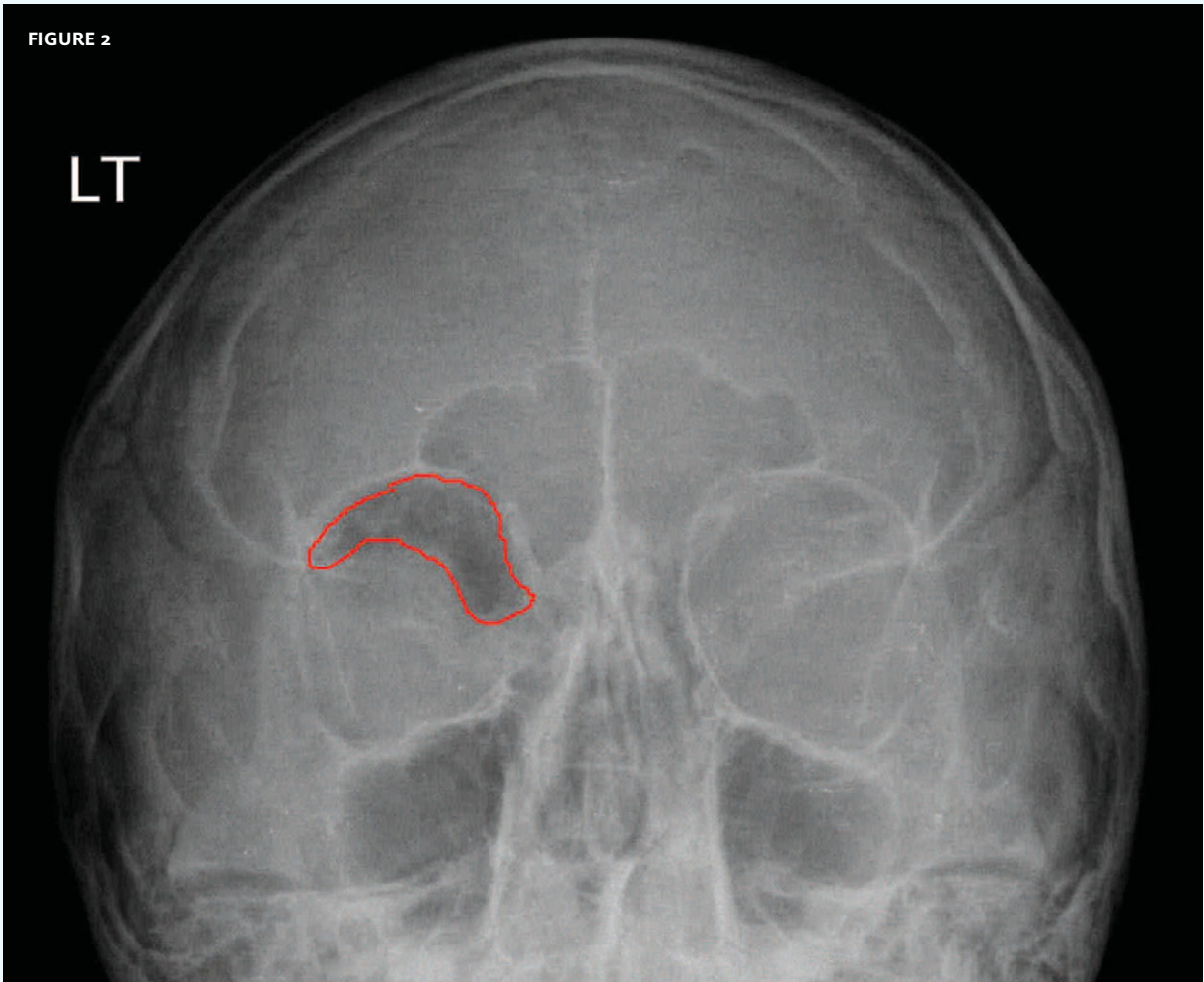
View the image taken (**Figure 1**) and consider what your diagnosis and next steps would be.

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2

LT



The x-ray shows air in the orbit, which may indicate a fracture of the orbit and communication with an airspace in the skull.

The swelling stemmed from subcutaneous emphysema—itsself a sign of orbital fracture.

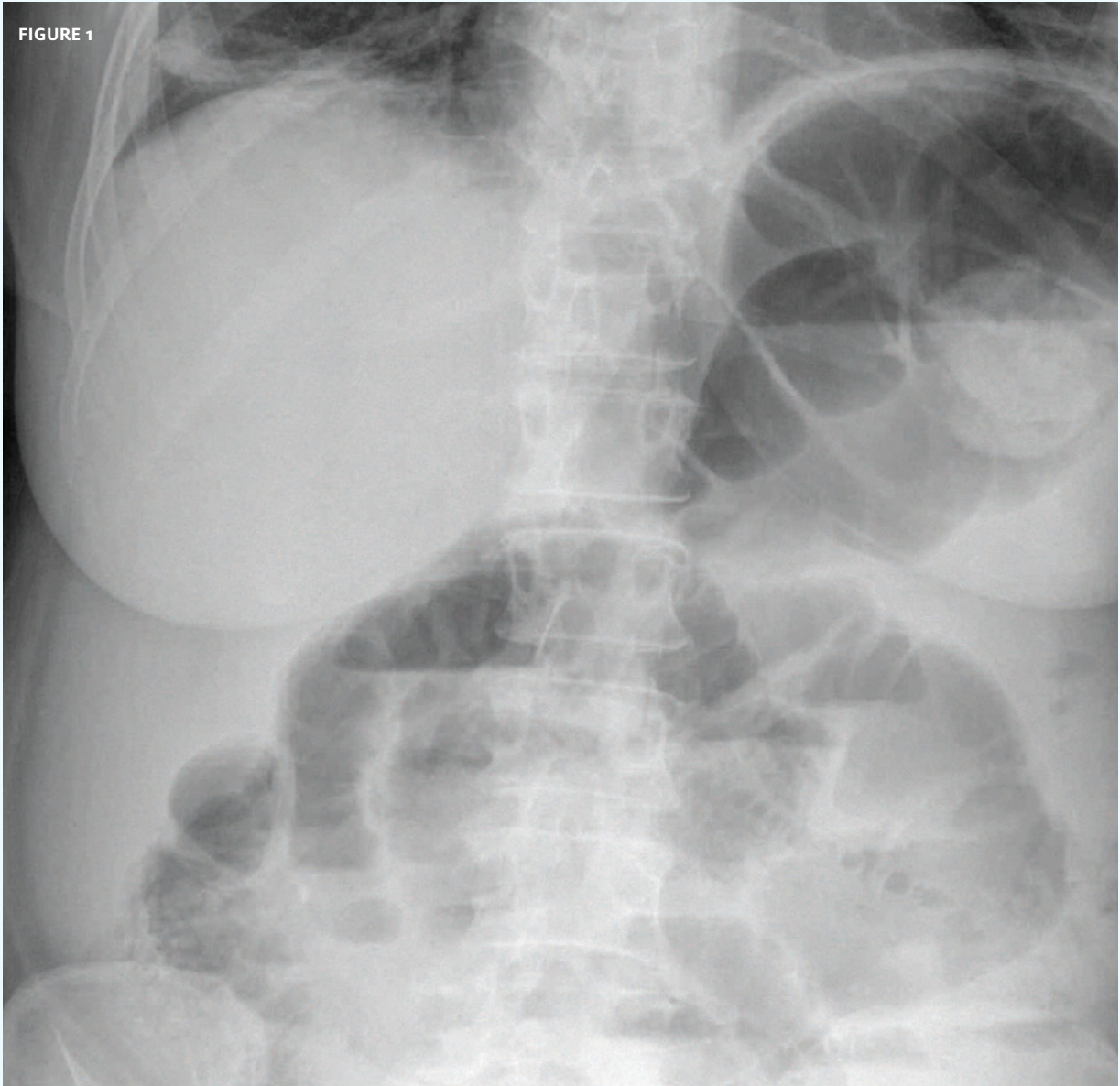
This patient was referred for CT evaluation.

It should be noted that the false negative rate with plain films for facial trauma is high. CT is the study of choice. If CT is not available, referral should be based on clinical suspicion in light of the history and physical findings. High-energy trauma deserves a high index of suspicion.

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



FIGURE 1



The patient is a 54-year-old woman who presents with a one-day history of abdominal pain and nausea.

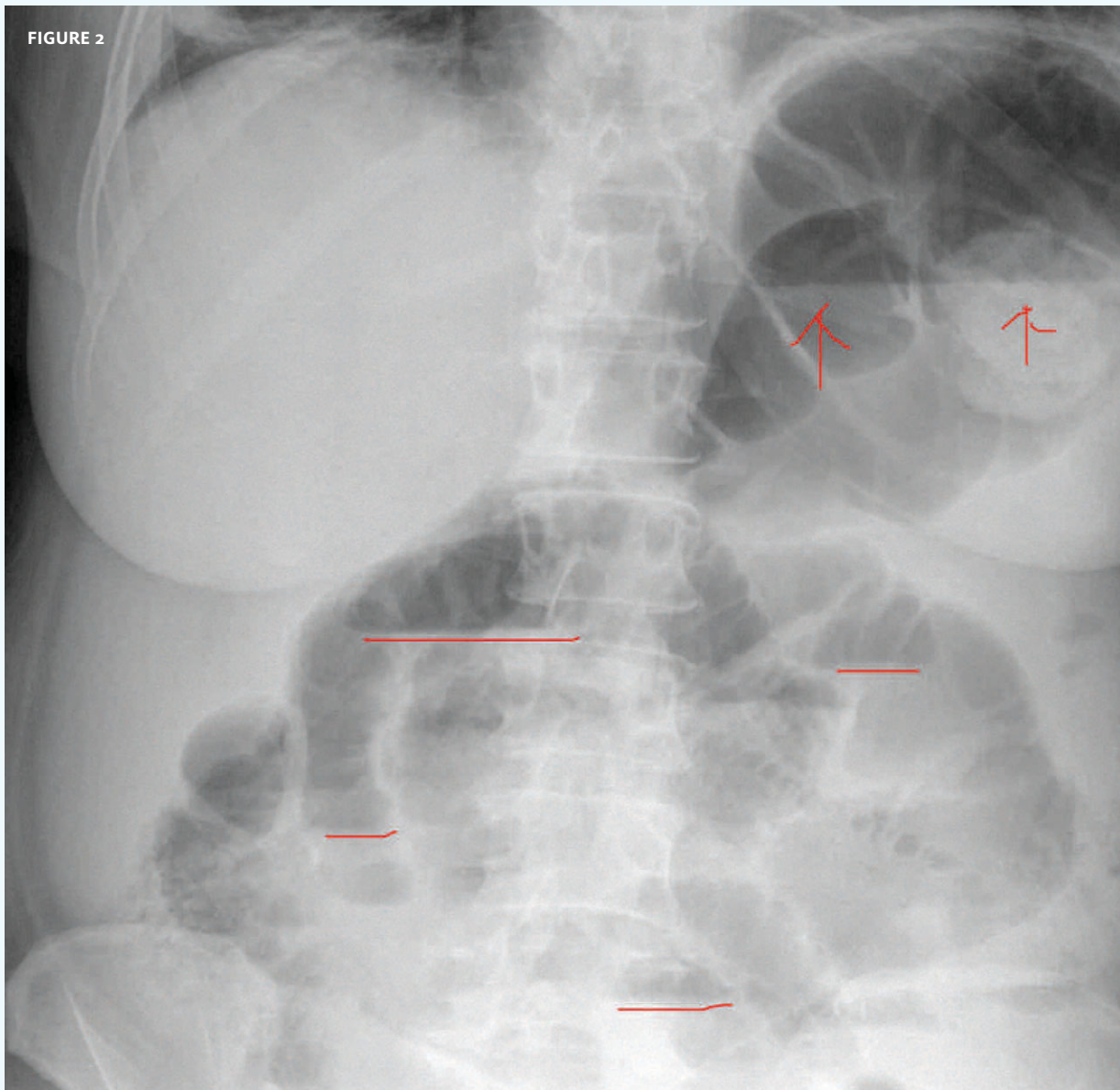
On exam, you note distended abdomen with diffuse tenderness and rebound.

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

FIGURE 2



This patient had a small bowel obstruction and right lower lung atelectasis. She was referred to the hospital for management.

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

These cases are among 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.



ABSTRACTS IN URGENT CARE

On Stroke Prevention in Patients with Stroke, TIA, and Atrial Fibrillation, Lung Imaging and PE, and Concussion in Children

■ 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.

New Guidelines for Prevention of Stroke in Patients with Stroke or TIA

Key point: *New, evidence-based recommendations aim at reducing risk of ischemic stroke in patients who have had a stroke or transient ischemic attack.*

Citation: Furie KL, Kasner SE, Adams RJ, et al. Guidelines for the prevention of stroke in patients with stroke or transient ischemic attack. A guideline for healthcare professionals from the American Heart Association/American Stroke Association *Stroke*. 2010 Oct 21. [Epub ahead of print].

The aim of this updated statement is to provide comprehensive and timely evidence-based recommendations on the prevention of ischemic stroke among survivors of ischemic stroke or transient ischemic attack.

Evidence-based recommendations are included for the control of risk factors, interventional approaches for atherosclerotic disease, antithrombotic treatments for cardioembolism, and the use of antiplatelet agents for non-cardioembolic stroke.

Further recommendations are provided for the prevention of recurrent stroke in a variety of other specific circumstances, including arterial dissections; patent foramen ovale; hyperhomocysteinemia; hypercoagulable states; sickle cell disease; cerebral venous sinus thrombosis; stroke among women, par-

ticularly with regard to pregnancy and the use of postmenopausal hormones; the use of anticoagulation after cerebral hemorrhage; and special approaches to the implementation of guidelines and their use in high-risk populations. ■

Dabigatran Approved for Stroke Prevention in Atrial Fibrillation

Key point: *The FDA has approved the oral anticoagulant dabigatran (Pradaxa) to prevent stroke and blood clots in patients with A fib.*

Citation: U.S. Food and Drug Administration. FDA approves Pradaxa to prevent stroke in people with atrial fibrillation. October 19, 2010. Available at: <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm230241.htm>

Approval follows the RE-LY trial, in which dabigatran was non-inferior to warfarin in terms of a combined endpoint of stroke or systemic embolism. There were also fewer hemorrhagic strokes with dabigatran.

Where warfarin requires patients to undergo periodic monitoring with blood tests, no such monitoring is necessary with dabigatran.

The drug, a direct thrombin inhibitor, will come with a medication guide to warn patients of the potential for serious bleeding. Other side effects include gastrointestinal symptoms. ■

Lung Imaging Might Not Be Beneficial for Diagnosis of Pulmonary Embolism

Key point: *A decision analysis led to the surprising conclusion that health outcomes would be maximized and costs mini-*



Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the JUCM Editorial Board.

mized by eliminating lung imaging altogether.

Citation: Duriseti RS, Brandeau ML. Cost-effectiveness of strategies for diagnosing pulmonary embolism among emergency department patients presenting with undifferentiated symptoms. *Ann Emerg Med.* 2010;56(4):321-332.

Investigators constructed a decision model to determine the most cost-effective diagnostic strategy for pulmonary embolism (PE). They evaluated 60 strategies that differed according to tests used, test order, and values of numerous parameters (e.g., cutoff for a “normal” D-dimer result).

The diagnostic tests were D-dimer measurement, lower-extremity compression ultrasonography, computed tomography (CT), pulmonary angiography, and ventilation-perfusion scanning. The analysis relied on numerous assumptions, most importantly that 1.96% of patients tested for PE actually had PE.

The most cost-effective strategy was as follows:

1. Categorize risk using Wells score modified by whether deep venous thrombosis is clinically evident.
2. Measure D-dimer, using different cutoffs for different risk categories.
3. If D-dimer negative, PE is ruled out; if D-dimer positive, perform compression ultrasonography.
4. If ultrasound is negative, PE is ruled out.
5. If ultrasound is positive, PE is ruled in; treat with no further testing.

The advantage of the preferred strategy was slight. Chest CT or ventilation-perfusion scanning to prove that PE is present or absent would not add benefit (but would add cost); this finding did not change when assumptions were varied across their plausible ranges in sensitivity analyses.

This paper challenges existing practice by suggesting that pulmonary imaging is slightly counterproductive in the diagnostic work-up of pulmonary embolism. Remarkably, the authors reached this conclusion even though they accounted for the cost of malpractice suits for missed PE. If a prospective trial validates the safety and effectiveness of this approach, a substantial reduction in chest CT scanning could ensue.

[Published in *J Watch Emerg Med*, October 1, 2010—Daniel J. Pallin, MD, MPH.] ■

Clinical Report on Concussion in Children

Key point: An AAP clinical report outlines the diagnosis and management of sport-related concussion.

Citation: Halstead ME, Walter KD, The Council on Sports Medicine and Fitness. Clinical report—Sport-related concussion in children and adolescents. *Pediatrics.* 2010;126(3):597-615.

A comprehensive report from the American Academy of Pediatrics reviews recent data and presents important recommendations about the diagnosis and management of concussion in

children and adolescent athletes. Highlights of the report include the following:

- The five major features of concussion are:
 - direct blow to the head or face
 - rapid onset of short-lived impairment
 - functional rather than structural injury
 - clinical symptoms that vary in severity
 - and no abnormality on neuroimaging.
- Loss of consciousness is uncommon (<10%).
- Signs and symptoms of concussion include physical, cognitive, emotional, and sleep abnormalities.
- Loss of consciousness and amnesia might indicate more severe injury.
- On-the-field assessment should include evaluation of airway, breathing, and circulation; stabilization of the cervical spine if indicated (e.g., for athletes found unconscious); neurological examination; and orientation assessment with a brief standardized questionnaire (provided in the report’s appendix).
- Conventional neuroimaging is usually normal; if concerns about intracranial hemorrhage exist, computed tomography is the test of choice during the first 24 to 48 hours after injury.
- Although neuropsychological testing following concussion has become more common, no guidelines inform when to administer such tests.
- Cognitive and physical rest is recommended following concussion. For example, school work should be modified to avoid exacerbation of symptoms.
- Concussion rehabilitation consists of five stages that precede return to play:
 1. no activity
 2. light aerobic activity
 3. sport-specific exercise
 4. non-contact training drills
 5. full-contact practice

Athletes progress through each stage after remaining asymptomatic for 24 hours.

- A symptom-based approach—not a previously used injury grading scales—should be used to determine return to play. (Some symptom checklists are provided in the report.) Timing of return to play should be individualized, but under no circumstances should athletes return to play on the day of the concussion
- Recovery in children and adolescents typically takes seven to 10 days and is usually longer than for college or professional athletes.

This report is a “must read” for clinicians involved in the care of children or adolescents with sport-related concussion.

[Published in *J Watch Pediatr Adolesc Med*, September 29, 2010—Howard Bauchner, MD.] ■

Continued on page 36

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Practice Management

Bridging the Management Divide: Understanding Physician Leadership

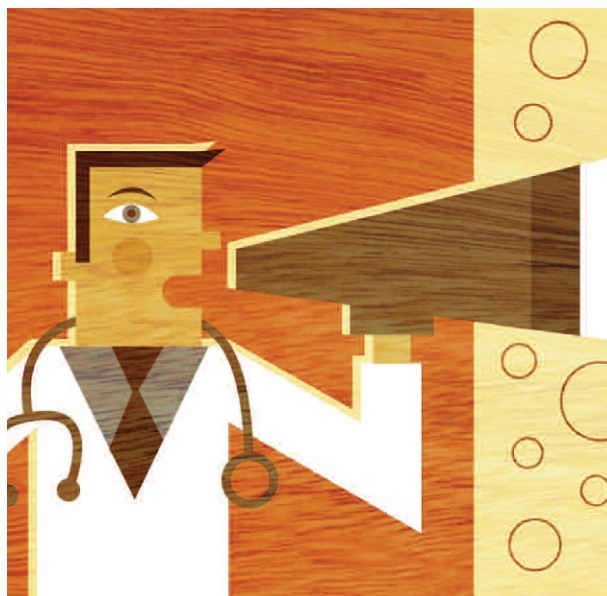
Urgent message: Physicians are trained for clinical care; administrators are trained for business management. These differences can create conflict regarding how healthcare is (and should be) managed. So what happens when the physician is the administrator?

Trevor Rohm, MD, MS

Introduction

There is a philosophical division between physicians and healthcare management/administration. There are a variety of causes for this great divide, but understanding how physicians think, act, listen, and learn can provide invaluable insight into how to best involve them in leadership positions, which leadership styles work best for this unique group, and how to improve healthcare management through physician leadership.

The urgent care physician, typically, plays many roles in the course of a day: clinician, counselor, mentor, educator, employee, boss, partner, friend, and teacher. When the worlds of clinical medicine and business management and healthcare collide, however, some of these roles come into conflict with each other—



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to the point that we might add “combatant of the healthcare management and administration.”

Our clinical training prepared us to care for patients, not dollars. As medical practitioners, we seek improved patient care, not improved profits. I want the clinic to run smoothly, my staff to be happy, and patients to be satisfied. Most of us are accustomed to others making sure that the business end of things works well.

We want to get paid, of course, with a raise and maybe a bonus, but we have not been directly involved

in making sure those things happen. We have not been involved in the fine details.

The standard relationship between clinician and administration through the ages might be characterized thusly: “I need your help to succeed, and you need my

services for your employment and the profits. You can't tell me what to do because I have specific training for what I do as a doctor, and I can't tell you what to do because you are my boss, you are the administration."

The entrepreneurial nature of urgent care often casts us in the role of clinician and administrator, however. We are in the position of mandating from on high, seeking profits, and dictating policy.

Healthcare Management

There are two fundamental divisions of medicine: the clinical aspect of medicine and the business of medicine. All physicians are clinicians; this is what our training encompassed. We have learned through experience that there is a fundamental lack of understanding of how a physician trains, learns, and practices, as evidenced by "the mismatch between what doctors were trained for and what they are required to do."¹

Medical training is based on principles, not specific job tasks. Physicians are trained for clinical practice, but our job requires understanding of the business of medicine, which is not taught. Physicians deal with individuals; our focus is not dealing with organizations.² Medical school is not business school.

Clinical expertise and experiences are a manifestation of the time and the volume of patients seen and evaluated throughout the course of clinical care. All medical training is focused on the clinical aspect of medicine (meaning how to render and make complex medical decisions) and how it affects, and effects, patient care.

Prestige, respect, and time all provide a clinician with the mantle of leadership in a clinical setting. The clinical setting is not, however, a business setting. In the business world, experience is important, but not always an indicator for good leadership.³ Experience counts, though it is not everything as pertaining to the clinical setting. Time does not equal experience. There is a great need for new training in order to produce physician leaders.⁴

There have been four key components identified that explain the need for the development of physician leaders:⁵

1. Healthcare organizations are complex, and physicians already know how to manage such organizations.
2. Physicians are already leaders in the clinical setting; they are not blind followers.
3. Physician leaders are currently chosen based on experience, not necessarily leadership qualities.
4. Physician training programs are not managerial-based, but clinically focused.

By using resources already available⁶ and incorporating

the clinical leaders into traditional management roles, by educating them with leadership theories, qualities, and training, the goal is to improve the overall healthcare administration by using those individuals who already understand the system and all its complexities.

Leadership Theories

A variety of leadership theories apply to physician leaders. Each is unique and offers an array of tools that can be used to improve the use of physician leadership in healthcare management and administration.

- Employee-oriented behavior theory is a leadership model that focuses on relationships between "managers" and employees.³ This leadership model seems a natural for physician leaders who spend their whole lives developing relationships. The goal of this model is to build relationships so that you can ultimately improve productivity in your employees (such as other physicians and staff) and increase employee job satisfaction. Employee-oriented behavior theory is a natural fit for physician leaders.
- Transformational leadership is a leadership process which inspires employees to focus on the goals of the organization, rather than self-serving purposes.⁷ Physicians and physician leaders understand that patient care is the only important clinical outcome, which is in the best interest of any healthcare organization.

This leadership model is consistent with physician goals for clinical care and should adapt easily for physician leaders. Evidence supports the theory that by focusing on the needs of the "follower," relationships can grow and help to produce effective leaders.⁸

- The Fielder contingency model of leadership is another tool that physicians can use to lead and guide their colleagues. The Fielder model attempts to match a leader's style with the leadership situation.³

The Fielder model is based on three basic principles:

1. Identify leadership style to match the type of situation. Leadership styles are task-oriented or relationship-oriented. Physician leaders understand clinical care and can adapt easily to this model because they are already relationship-oriented.
2. Evaluate and define the desired situation based on the following contingency factors: leader-employee relationships, the degree of task structure, and the influence and power the leader yields. Most clinical care is very structured in the clinical

setting, so physician leaders can be expected to lead efficiently.

3. Improve leader effectiveness to find a leader to fit a situation or change the situation to fit the current leadership style. Physician leaders understand the complexities of modern medicine, which makes most situations static and can help physician leaders qualified to adapt to each situation.

Physician Leadership

Each leadership theory is unique and may not apply to every piece of clinical work. As previously explored, there are a number of unique attributes and skills that physicians possess, and while not always recognized as leaders by administration, they are indeed leaders.⁹ Physicians guide, lead, and coordinate the complex task of clinical care. We manage patients, sometimes numbering in the thousands, and help each patient with his or her own unique medical problems. While these skills do not always translate into managerial business fortunes, they have similarities.

There is an unwritten code in medicine. I hesitate to share it, for fear of breaking the code, but it must be spoken and understood: clinical expertise equals leadership in the clinical settings. The whole of medical education is based on it; the long nights, tedious hours, and experience of endless patient care add up to what we call residency training. All physicians must endure this hardship, must learn what needs to be learned, must cross the proverbial bridge from bookwork to clinical application, and must receive their mantle of clinical care.

This is how physician leaders are made: by walking the path that has been walked before, by crossing the bridges that all physicians have crossed. In the clinical world, experience equals leadership. But this leadership is clinical, not managerial.

In the course of clinical events, however, managerial tasks are encountered. Physicians learn what makes nurses and staff members irate; we know the frustrations of inadequate scheduling, and understand the headaches in the current healthcare system. We run, maneuver, guide, manage, and manipulate the system for each patient we encounter. We understand not only the complexities of clinical care, but also the complexities that are in the healthcare system. While spreadsheets and profit margins are not in the daily clinical routine, patients' lives hanging in the balance are more important than profit margins. Managerial skills are gained through time and experience—which, combined with personal attributes, can make great physician leaders, even in the administrative realm.

Data suggest that physician leaders must exhibit some com-

mon characteristics in order to be successful leaders:¹⁰

1. Knowledge
2. People skills
3. Emotional intelligence
4. Vision
5. Organizational orientation

Most of these characteristics are incorporated by many physicians, but not all. However, these skills are also necessary to care for patients, which may explain why physicians can easily become administrative leaders.

Conclusion

There is a great need for physicians to cross the divide and become leaders in the managerial and administrative services of healthcare. They alone, with their patients, know the frustrations and barriers that pre-empt quality patient care. By learning the goals and unwritten rules of administration, by gaining and understanding the business of medicine, physicians can become the leaders that healthcare has been lacking. Physician leaders understand what cruel restrictions are placed on them and their partners by decrees, sent from above, mandated from on high, with little to no knowledge of how the patient care system actually works.

Many physicians *are* crossing the divide to become leaders; this is, after all, much easier than it is for an administrator to get accepted into medical school and become a physician.

Crossing the divide is not always easy, and may not even be desirous, but it is necessary to improve our administrative services and overcome any and all suspicions between physicians and administrators.¹¹

By applying formal leadership theories, physicians can be trained to apply their knowledge, experience, and expertise to healthcare administration. ■

References

1. Smith R. Why are doctors so unhappy? There are probably many causes, some of them deep. *BMJ*. 2001;322(7294):1073-1074.
2. Edwards N, Kornacki MJ, Silversin J. Unhappy doctors: What are the causes and what can be done? *BMJ*. 2002;324(7341):835-838.
3. Robbins S, Judge T. Basic approaches to leadership. In: *Organizational Behavior*. 11th ed. Upper Saddle River, NJ: Pearson Prentice Hall; 2005.
4. Pronovost P, Miller M, Wachter R, et al. Physician leadership in quality. *Acad Med*. 2009;84(12):1651-1656.
5. Stoller JK. Developing physician-leaders: Key competencies and available programs. *J Health Adm Educ*. 2008;25(4):307-328.
6. Robbins C, Bradley E, Spicer M. Developing leadership in healthcare administration: a competency assessment tool. *J Healthc Manag*. 2001;46(3):188-202.
7. Robbins S, Judge T. Contemporary issues in leadership. In: *Organizational Behavior*. 11th ed. Upper Saddle River, NJ: Pearson Prentice Hall; 2005.
8. Menaker R, Bahn R. How perceived physician leadership behavior affects physician satisfaction. *Mayo Clin Proc*. 2008;83(9):983-988.
9. Parsons J. Small "I" leadership. *Aust Fam Physician*. 2009;38(5):277.
10. Taylor C, Taylor J, Stroller J. Exploring leadership competencies in established and aspiring physician leaders: An interview-based study. *J Gen Intern Med*. 2008;23(6):748-754.
11. Edwards N, Marshall M. Doctors and managers. *BMJ*. 2003;326(7381):116-117.



Preventing the “*Delta Uniform*,” or, Malpractice Reduction in the Urgent Care Center

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

A few years ago, I flew over to San Diego to watch the Red Bull Air Races. A friend of mine who is a pilot occupied the right seat and another friend (also a pilot) was in the back of the plane seated with another friend. As we got closer to San Diego, I noticed that a thick inversion layer (dense fog) blanketed the coast. The lack of visibility required me to shoot an instrument approach into the airport.

If you have ever flown into San Diego International on a commercial flight, you probably approached from the east, landing on runway 27. As you may recall, there are some tall hills just to the east of the airport. The elevation of these hills requires a “non-standard” steep approach to land.

Bluntly, I screwed it up. I was too high on the approach and ultimately had to “go missed,” an aviation term meaning, in this case, to go to the end of the line.

Unfortunately, this meant I was now number 28 in line for landing. I did not have enough fuel for an hour of holding patterns (FAA only requires enough for 30 minutes), however, so I diverted to a nearby airport, refueled, and rejoined the line of planes landing in San Diego. As I was re-entering the approach, my fair-weather pilot friend gave me the sage advice, “Don’t ‘dick up,’ this time.”

Since this somewhat sketchy admonition isn’t always appropriate to say, the phrase *delta uniform* was born (“delta” being the military alphabet’s version of the letter “d” and “uniform” signifying the letter “u”).

My new mantra to urgent care providers and owners who ask me how to prevent medical misadventures is simply to say, “Don’t delta uniform.”



John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of JUCM. He may be contacted at JohnShufeldt@shufeldtconsulting.com.

At this juncture, you may be asking yourself, “Why do they let this guy write articles?” If you are not asking that question, you may instead be asking, “What are the most common ways urgent care center’s ‘delta uniform’?”

In no particular order, after 17 years practicing urgent care medicine and helping to defend urgent care providers as an attorney, here are the most common areas prone to the delta uniform:

1. Discharge instructions. Lack of proper discharge instructions is a common root cause for urgent care malpractice. Here’s how it happens: Let’s say a patient gets sent home with the diagnosis of a urinary tract infection, along with a prescription. The written instructions advise the patient to follow up with her primary care physician in seven to 10 days for a repeat urinalysis, and to drink plenty of fluids. The patient starts the antibiotics, which she believes may be making her vomit. Ultimately, she keeps the medication down about 50% of the time. In the interim, she becomes dehydrated, and develops flank pain and an elevated temperature.

By the time she realizes that it may not be the medication causing her problems, she has gram negative sepsis from pyelonephritis, is very dehydrated, and goes into renal failure. She has a protracted medical course and ultimately develops renal insufficiency. All this stemming from a simple UTI.

You may be thinking that she should have come back immediately when she became sicker. Unfortunately, not all patients are that smart. If the discharge instructions had said the following, the outcome of the suit would have been much different:

- a. Repeat exam with your provider or back here in two days.
- b. Return immediately or go to the emergency de-

partment if worse or no better by the second day.
c. If you cannot keep your medication down, or if you stop producing your usual amount of urine, you need to return or go to the ED immediately.

These instructions give the patient a very clear framework of what to watch for.

After 25 years in medicine, here is what I've learned: the ones who should return don't, and the ones who don't need to return do. Therefore, you have to spell it out in simple English (or the patient's language).

2. Lab and x-ray results. Not following up on results is an enormous source of malpractice litigation in all primary care practices.

Example: A 40-year-old male patient presents on Thursday with a fever, swollen lymph glands, and an enlarged spleen. He is examined and the provider orders a simple blood count for a suspected viral illness. Ultimately, the patient is sent home with the admonition to take acetaminophen, drink plenty of fluid, and to rest.

Subsequently, his CBC comes back with an Hb of 9, platelets of 15,000, and an absolute neutrophil count of 150/ul. These extremely significant lab findings are missed by the back office tech and sit on the desk of the provider for the entire weekend. On Monday, the provider on duty sees these results, correctly interprets them as worrisome for acute lymphoblastic leukemia, and calls the patient back—only to learn he died the day before from overwhelming sepsis.

Take-home point: All labs results must be reviewed by the provider, entered in the chart, and the patient called back even if they interpreted as “normal.”

3. Radiology over-reads: Not having *all* x-rays over-read by a board certified radiologist is another common reason for medical malpractice in the urgent care.

Consider the 48-year-old nonsmoker who presents with blunt chest wall trauma from a motor vehicle accident. The provider orders a chest x-ray and reviews the films for signs of rib or clavicle fractures, pneumothorax, and widened mediastinum. She correctly determines that none of these finding are present. The patient is discharged home with pain meds and appropriate instructions.

Six months later, the patients goes to his PCP with weight loss, cough, fatigue, and hemoptysis and is ultimately diagnosed with small-cell lung cancer. The films taken six months ago during the visit for blunt chest trauma reveal that the patient had a mass on their lung which ultimately proved to be the cancer. The

urgent care provider had been so intent on looking for trauma that he missed the rather subtle shadow in the superior lobe.

All x-rays taken in the urgent care center need to be reviewed by a board-certified radiologist. I have heard some owners opine that to save money, they only send out the “high-risk” films for review. This is akin to saying, “I will only wear a helmet on a motorcycle when I think I may crash.” High-risk films are rarely missed; the miss occurs on the “easy” films where the finding is incidental but very serious.

4. Service recovery. Not addressing patient complaints in a timely manner is a frequent inciting event for an eventual malpractice claim. Bottom line is that angry patients sue providers. Therefore, “keeping the patients happy” is a great mantra to encourage the staff to act professionally and courteously. Parenthetically, the best way to encourage your team to treat the patients compassionately, is to treat your team with the respect and compassion they deserve.

When the service falls below the patient's expectation and an angry patient contacts you complaining about the care or service, swallow your pride, listen, and make it right. When you do this, two things happen: you maintain the relationship and they tell others about the lengths you went to ensure their happiness; most importantly, their anger is diffused so they are less likely to have their day in court.

5. Informed consent. Failure to provide and document informed consent, particularly when the patient does not want to have a test performed or be sent to the emergency department, is a common issue during malpractice suits.

A 55-year-old male presents alone with atypical chest and shoulder pain. He has a normal EKG, troponin, and chest x-ray. Despite the normal tests, the provider correctly tells the patient that a further work-up is needed and recommends transfer to the ED. The patient refuses and ultimately goes home and dies from an acute myocardial infarction.

Written on the chart is, “Go to the ED for further work-up.” The family sues and argues that had the patient known the potential grave danger he was placing himself in, he would have followed the recommendation of the provider and gone to the ED.

Ultimately, the family is awarded a high seven-figure amount.

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Disciplined Time Management Drives Your 2011 Marketing Plan

■ FRANK H. LEONE, MBA, MPH

By the time you read this, your clinic should have a 2011 marketing plan firmly in place. Even if you do, that plan is only a piece of paper (and/or an electronic file) if—as is commonly the case—it is not executed in a resolute manner.

Here is what you need to do in order to ensure your plan becomes your practice:

1. Pepper your plan with date-specific action steps and remain committed to this schedule.
2. For every marketing tactic (e.g., a monthly tip email blast), create and calendar a series of mini-steps (e.g., create a six-month “tip inventory”).
3. Spread out each mini-tactic over the entire year. Make a specific day (e.g., Monday) Marketing Tactic Day and be disciplined in *never* failing to execute that week’s mini-tactic.
4. Set a date to develop your 2012 marketing plan (November 2011 will do), with a full array of mini-tasks. Learn from your 2011 experience and avoid waiting until January 2012 to initiate this process.

Discipline Continues on the Sales Side

Discipline on the “sales side” involves two significant issues: *time management* and *playing the numbers game*. Time management is the essence of effective sales. It’s mathematical: carve out 20% more time for sales and your numbers go up by 20% or more.

Monitor your time allocation through the maintenance of *honest* weekly time sheets. Do not drift away from this commitment; keep your timesheets going through both good times and bad, look for shortfalls on your part—then mini-

mize or eliminate those shortfalls.

1. Do what works, not just what you enjoy doing. Mastering the discipline to carve out 10 minutes a day for brief phone messages means you could literally leave 2,500 voicemail messages during 2011, assuming a 50-week work year. That tactic represents market penetration for 10 minutes a day.

Making such calls is certainly not as “sexy” as a face-to-face meeting, but in the aggregate may be more fruitful when measured by the hour. Get a handle on what works.

2. Learn to say no. Many occupational health professionals report to professionals in another discipline (e.g., a clinician) who view the sales professional as a utility player that is perpetually available to address any miscellaneous ad hoc activities. Guard your precious time like a hawk.

The numbers game

The “numbers game” is where the rubber hits the road. Set quotas for key tasks that will help you complete the big picture, and commit to them. Small steps taken in a disciplined fashion every day or every week increase your exposure exponentially over the course of a year. Here are some examples:

1. **Introductory letters per week.** Keep your pipeline full. If you fall behind in the pipeline game, you will invariably spend unproductive time just trying to catch up.
2. **Sales-oriented phone calls.** This varies every day, but should be fairly consistent over the course of a week. In order to keep your appointment dance card full, you need to be disciplined in making your introductory calls. Many of your peers—and competitors—are not.
3. **Live sales calls.** You should be making three or four

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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.

If the provider had taken the time to write, “I discussed the fact that he is at risk for a heart attack and that he needs to go immediately to the emergency department for further workup and monitoring. Understanding the risk of death or serious illness, the patient, who is competent and verbalizes understanding of the risks, refuses to go to the ED, etc.”

This simple paragraph would take only a few minutes to hand write (or seconds to click if you have a macro in the electronic medical record) and would have saved the practice and provider from financial ruin.

6. Order sets. Not having protocols or standing orders for potentially high-risk conditions, in other words. The three previous Health Law columns published in *JUCM* discuss this in detail.

Bottom line: Good providers and urgent care staff make simple mistakes when busy or stressed. The use of standing orders has been shown to prevent medical misadventures, ultimately lower the cost of health-care, and make the practice more efficient.

7. Poor hiring practices. Hiring rude or inadequately trained staff members and providers is a guaranteed inciting event for medical malpractice. The jury is still out on whether or not you can teach people to be nice. My gut tells me that kindness and compassion are probably inherited traits, and that coaching people to be more kind is akin to trying to coach someone to change their sexual orientation, so unless you make the “right hire” don’t count on being able to teach them the requisite skills.

The take-home point is this: Providers or staff that don’t know the center’s policies, are rude to patients and other staff members, or are negativity mongers have no business working in healthcare. Not only will they predispose your clinic to malpractice suits, they will chase off good team members who don’t want to work in such a toxic environment.

8. Documentation. Poor, illegible, or inadequate documentation is often the final nail in the coffin when trying to defend care which may border on the standard. Many times I have seen a case rest on documentation. Poor handwriting, scant documentation, and not documenting the pertinent negatives are ultimately what the case turns upon. Spend the money to purchase an EMR system which forces your providers to be thorough, complete, and legible with their documentation. If implemented properly, I guarantee the return on

“It is the provider, not the business, that is reported to the National Practitioner Data Bank, so the onus is on you.”

investment on the EMR purchase and adoption will be significant, lasting, and lifesaving.

9. Callbacks. Performing callbacks on all patients acts as an early warning detector to identify patients who have complaints about the service, are not getting better, or have not made their follow-up visits. Patients love callbacks. They interpret this simple phone call to mean that you actually do care about them. It is the ultimate win-win-win. The patients love them, they prevent unnecessary suits, and the staff receives positive affirmation from grateful patients.

Trying to defend the urgent care practice or act as the “expert” on these particular issues can prove to be somewhat challenging, inasmuch as in every instance the defendant-provider or owner had to come up with some reasonable answer as to why they did not have adequate controls in place to prevent the ultimate delta uniform (or, in the case of x-ray over-reads, the rational basis for why other films would be chosen over what was ultimately the culprit x-ray for radiology over-read).

I would venture to say, if an urgent care organization thoroughly addressed each and every one of these areas, the amount of malpractice in our industry would be negligible.

Frankly, as a provider, I would not work for an urgent care practice that did not have these areas adequately addressed, particularly since at the end of the day, no matter the reason, you will forever own and have to defend the resultant delta uniform on every new hire application, hospital or health plan credentialing form, and state licensure submission.

Remember, it is the provider, not the business, that is reported to the National Practitioner Data Bank, so the onus is on you to ensure that adequate safeguards are in place before you start working. It is simply not worth it in the long run to subject your professional career and the lives of your patients to lax business practices.

In aviation terms, malpractice reduction is all about preventing the *delta uniform* so that you don’t go *tango uniform* (I’ll let you figure that one out for yourself!). ■



Coding for Complicated or Multiple I&Ds, Head CT, and Follow-ups—and When to Use CPT 99051

■ DAVID STERN, MD, CPC

Q I notice that the code for complicated or multiple incision and drainage (I&D) produces almost twice the reimbursement as the superficial I&D code. When can I code the code 10061 (Incision and drainage of abscess, e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia; complicated or multiple)?

- Anonymous

A. The concept of multiple (i.e., more than one) is straightforward. The concept of *complicated* I&D is less clear. CPC Assistant is quite ambiguous, as it states: "The choice of code is at the physician's discretion, based on the level of difficulty involved in the incision and drainage procedure."

One indication that the code for complicated I&D is appropriate is that the fluid is being drained for tissues deeper than the epidermis, dermis, and subcutaneous tissue. Of course, it is important for the physician to document in the procedure note what deeper tissues are involved. ■

Q I have a question about CT. If you do a CT of the head using the code 70450, does that code include the reading, or is there another we should bill for the interpretation of the scan?

- Cheryl Kennedy

A. When you bill the code 70450, the code includes the reading of the study. Radiology codes include both the technical component (equipment and personnel involved in performing and preparing the study) and the professional component (physician reading of the study). If you bill the code without a mod-

ifier, then you are billing for both the technical and the professional component.

Radiology codes can be split into their separate components by adding modifier -TC to bill only for the technical component and by adding modifier -26 to bill only for the professional component (physician reading of the study). ■

Q What is the appropriate code for an 18-month-old established patient that returns for a follow-up on acute suppurative otitis media with rupture of eardrum?

- Marcie, West Bloomfield, MI

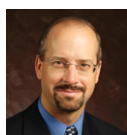
A. The concept of the follow-up visit is sometimes confusing. If the patient sees the provider for a routine follow-up visit during the global period for a procedure, then the code 99024 is the appropriate code. In the situation you bring up, however, there is no mention of a procedure, involving a global period, on the initial visit. Thus, assuming that the provider saw the patient for the follow-up visit, the provider should select the E/M code (99212-99215), based on the level performed and documented in the patient's medical record. ■

Q We are hoping to could get your help answering a coding question. We have a day clinic with operating hours 8:00 a.m. – 1:00 p.m. by appointments only. The facility is considered a freestanding urgent care facility with operation hours of 1:00 pm – 8:00 pm. We know that we have to bill E/M CPT codes for the urgent care, but we are puzzled if we are allowed to use CPT 99051 after 5:00 pm.

- Toni Gonzalez

A. In regards to 99051, this is not an urgent care-specific code. The code may be used by any medical practice that provides regularly scheduled evening, weekend, and holiday hours.

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David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Dr. Stern speaks frequently at urgent care conferences. He is CEO of Practice Velocity (www.practicevelocity.com), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

CODING Q & A

Many payors may not reimburse for this code. Some payors may reimburse for this code, but only if the payor has the practice you envision enrolled as a true urgent care center.

It is important to note that your practice would not accept walk-in patients during all hours of operation. Thus, this practice does not meet the UCAOA criteria of a true urgent care center. ■

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ABSTRACTS IN URGENT CARE

Delaying Appendectomy May Not Be Harmful for Adults with Acute Appendicitis

Key point: Findings validate the practice of treating acute appendicitis urgently rather than emergently.

Citation: Ingraham AM, Cohen ME, Bilimoria KY, et al. Effect of delay to operation on outcomes in adults with acute appendicitis. *Arch Surg.* 2010;145(9):886-892.

The goal of the study was to determine the impact of delay from surgical admission for acute appendicitis to induction of anesthesia on outcomes after appendectomy in adults, using data from 32,782 patients submitted to the American College of Surgeons National Surgical Quality Improvement Program.

The principal exposure was time to operation, and primary study endpoints were 30-day overall morbidity and serious morbidity or mortality.

Appendectomy was performed within six hours of surgical admission in 24,647 patients (75.2%), from more than six through 12 hours in 4934 patients (15.1%), and more than 12 hours after surgical admission in 3,201 patients (9.8%).

Although there were statistically significant differences in operative duration (51, 50, and 55 minutes, respectively; $p < .001$), these were not clinically meaningful. Similarly, the difference in length of postoperative stay (2.2 days for the >12-hour group versus 1.8 days for the remaining groups; $p < .001$) was not clinically meaningful.

In regression models, duration from surgical admission to induction of anesthesia did not predict overall morbidity or serious morbidity or mortality. There were no significant differences in adjusted overall morbidity (5.5%, 5.4%, and 6.1%, respectively; $p = .33$) or serious morbidity or mortality (3%, 3.6%, and 3%, respectively; $p = .17$).

In an accompanying invited critique, it is noted that these findings validate the practice of treating acute appendicitis urgently rather than emergently. ■

OCCUPATIONAL MEDICINE

sales calls every day. Given five days per week (minus holidays) over a 50-week work year, that is 900 live sales calls a year. How can you fail?! Manage your face time well; cluster your travel, map out the routes to your destinations, and keep meetings brief and to the point.

4. Emails. Dedicate an hour at the end of your day (e.g., 4:00 to 5:00 p.m.) to sending an email to virtually everyone you dealt with that day (in order to review and document your interaction). Send confirmation emails concerning your next day's activities, as well.

5. Clinic tours. Carefully planned clinic tours for prime prospects should be an integral part of every program's marketing plans. Schedule at least *three* clinic tours each week. That's 150 tours every year, during which prospects can see firsthand what you've been talking to them about on the phone, via email, and in face-to-face meetings.

Discipline is not easy and is not much fun. I am convinced, however, that discipline is the lifeblood of success. If you really want big numbers in 2011, commit to being laser focused on what is best for your sales output each and every hour of each and every day. You may be surprised at how it all adds up. ■

A Disciplined Plan for 2011

Daily	<ul style="list-style-type: none"> Complete 10 telephonic sales calls (both introductory and follow-up). Complete three or four "live" sales calls. Carve out an email hour including reviews, reminders of the next day's meeting, email responses, and internal briefings. Fine-tune your time management plan for the following day. Document your day's activity on your weekly time sheet. Leave five after-hours voicemail messages for clients and/or prospects.
Weekly	<ul style="list-style-type: none"> Execute the marketing tactic listed for that week. Review the previous week's timesheet; compare to year-to-date time allocation; adjust as necessary. Send out at least 10 introductory letters. Ensure that you complete at least <i>three</i> clinic tours.
Annually	<ul style="list-style-type: none"> Develop the following year's marketing plan by November.

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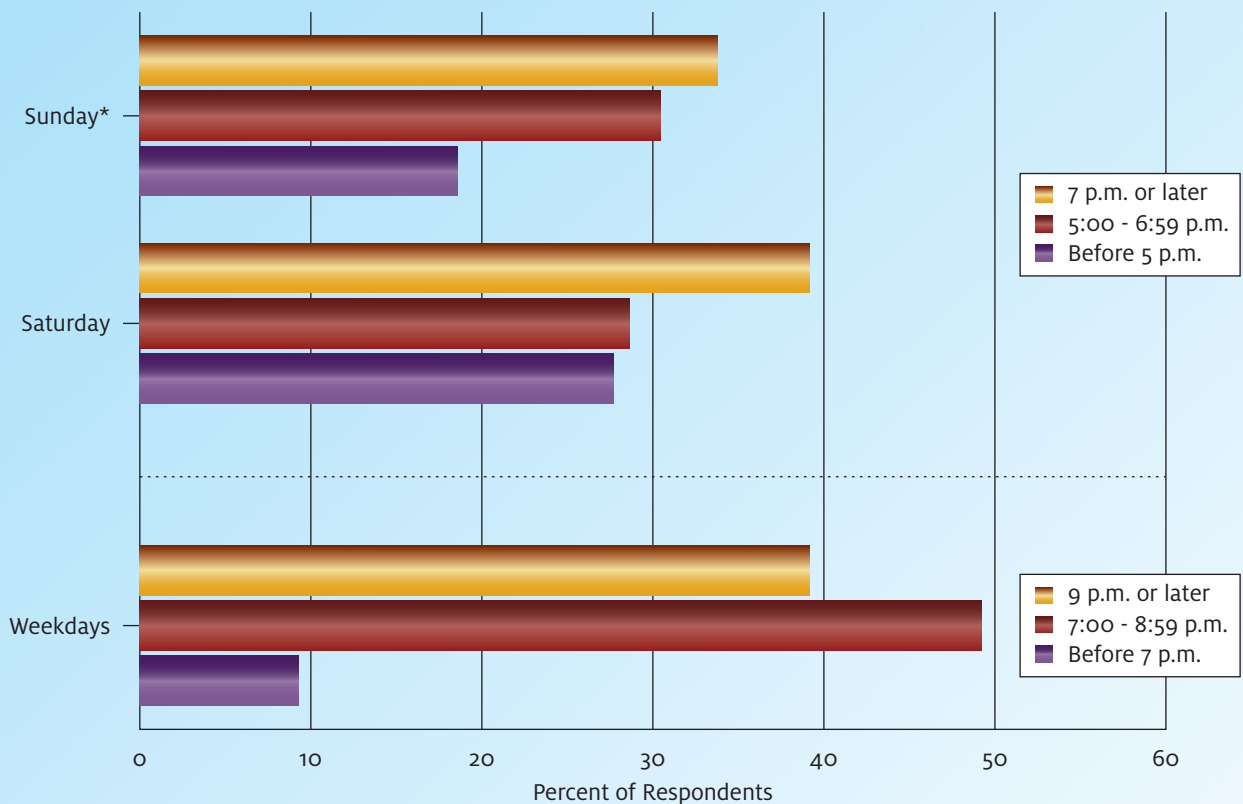


DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we offer another look at data from the most recent annual survey conducted by UCAOA. (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.)

In this issue: What time do U.S. urgent care centers close their doors to incoming patients each night?

CLOSING TIME



Note: Approximately 15% of responding centers reported being closed on Sundays.

Do you know what time your local primary care offices and retail clinics close? Maybe more to the point: Are your prospective patients aware of when they can visit, particularly if they need medical care at a time of day when the emergency room is the only other option?

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. We'll share your discovery with your colleagues in an upcoming issue of JUCM.

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