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Acute Stridor in Children

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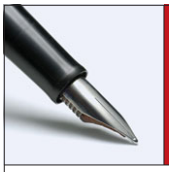


LETTER FROM THE EDITOR-IN-CHIEF

Our Infected Food Chain: Lessons from Groundhog Day

An *E. coli* outbreak, believed to have originated from a crop of bean sprouts in Northern Germany, has killed at least 36 people across Europe.

Watching the public health "crisis" unfold, I can't help but think of the 1993 comedy "Groundhog Day." Phil Connors (Bill Murray), an egotistical meteorologist from Pittsburgh tasked with covering the annual Groundhog Day in Punxsutawney, Pennsylvania, finds himself caught in a time warp in which he is forced to relive the events of the same day over and over again. By the end of the movie, Connors is able to break free of the endlessly repeating time loop when he uses his knowledge and experience to learn from past mistakes, stop his selfish ways, and begin helping people.

We seem to be stuck in a similar time warp when it comes to foodborne illness outbreaks. These outbreaks are not new, follow similar patterns, create fear and panic, cost millions of dollars, and are responsible for considerable collateral damage. Yet policymakers continue to repeat the same mistakes, afraid to make tough choices and forgo short-term self-interest to create a better, more sustainable future.

Crises like the current one in Europe will generate a lot of fleeting interest from health officials and politicians alike, but will quickly die down as the offending source is eradicated from the food chain and the natural cycle of the outbreak dies down. Then the next crisis dawns and then it's Groundhog Day all over again. Perhaps this is an opportunity for a little self-reflection and enlightenment.

Are public health agencies and politicians doing their part to protect us from unnecessary harm? What is the interplay between public health policy, special interests, and public will in determining our response? What are the long-term costs of current food handling and agribusiness policy?

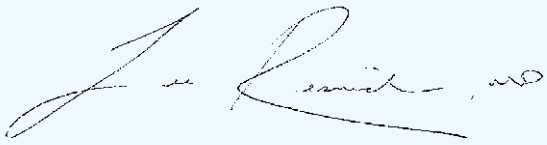
Consider the following:

- "Safe handling" by consumers does not guarantee safety (eg, washing contaminated vegetables will not eliminate *E. coli*).
- Separation of livestock from vegetable farms is critical to preventing outbreaks, yet regulations are loose and under-enforced.
- Indiscriminate use of livestock antibiotics almost certainly contributes to resistant foodborne illness.
- Overcrowding and other corporate farming practices almost certainly contribute to higher rates of foodborne illness.
- The rate of antibiotic-resistant infections (MRSA, *C. difficile*, etc.) is far outpacing the research and discovery of new antibiotics to fight them.
- Trying to outsmart the adaptability of pathogens is a losing battle.
- Adapting practices at all levels to reduce antibiotic resistance is prudent and necessary.
- Responding to public health scares is expensive.
- Collateral damage is significant. Foodborne illness scares cost many innocent producers millions of dollars of lost income. The same thing now happening in Europe happened to US spinach farmers during the *E. coli* outbreak in 2006, which spread to 26 states, infecting 199 people, including three who died. That outbreak was sourced to a few farms in California, yet all producers were affected.

However, the will to reform is lacking:

- Political will to reform agribusiness is limited, and special interests are very powerful and resistant to any reforms.
- Public will for higher food prices is nonexistent, despite the well-known risks associated with the very corporate farming practices used to lower costs.

The American people, and increasingly the rest of the world, are highly motivated by cheap food in large quantities. Yet safe and sustainable agribusiness practices will be necessary to break the cycle of multi-drug-resistant foodborne outbreaks. We will only escape from this endlessly repeating time loop when we use our knowledge and experience to learn from past mistakes, stop our selfish ways, and begin helping people! ■



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CLINICAL

9 Acute Stridor in Children

Acute stridor in pediatric patients is alarming to children, parents, and healthcare providers alike. Differential diagnosis is the key to initial evaluation and management of this worrisome symptom. Here is how to think it through.

Jerri A. Rose, MD, FAAP

PRACTICE MANAGEMENT

17 Dealing With the Disruptive Doctor

When a physician is dubbed "Tom the Terror," turning a blind eye can send patients and staff heading for the exit, wreck your reputation, and spark a lawsuit. Here's what to do instead.

Leonard D. Goodstein, PhD, ABPP, and John Shufeldt, MD, JD, MBA, FACEP

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IN THE NEXT ISSUE OF *JUCM*

Headaches are among the most common complaints in medicine. In the United States, more than 30 million people have one or more migraine headaches alone each year. Our September cover story discusses evaluation and management of headache due to subarachnoid hemorrhage, migraine with and without aura, tension headache, cluster and other autonomic trigeminal headaches, headache due to analgesic overdose, cevicogenic headache, and chronic daily headache. How are neurological findings assessed? Which headaches require immediate transfer to the hospital? What is the proper use of tools such as the MIDAS scale and the POUNDing mnemonic? These and many other questions are addressed in this enlightening, information-packed review.

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Mission Statement
JUCM *The Journal of Urgent Care Medicine* supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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Stridor, an externally audible sound caused by abnormal air passage during breathing, is alarming to physicians (not to mention children and their parents) because it could be a symptom of a wide variety of conditions, many of them life-threatening.

In her cover story on the subject, Jerri A. Rose, MD, FAAP, explains the pathophysiology of stridor and the potential causes of acute stridor in the febrile and afebrile child. These include croup, bacterial tracheitis, epiglottitis, retropharyngeal abscess, peritonsillar abscess, upper airway foreign body, thermal or caustic injury, spasmodic croup, anaphylaxis, hereditary angioedema, trauma, neoplasms causing airway compression, and psychogenic stridor.

Dr. Rose discusses evaluation and management of children with acute stridor, as well as management of acute laryngotracheitis (croup) and management of foreign body aspiration.

Dr. Rose is Assistant Professor, Division of Pediatric Emergency Medicine, at Case Western Reserve University School of Medicine, and Attending Physician at University Hospitals Case Medical Center in Cleveland, Ohio.

Another phenomenon that is alarming to patients, staff, and doctors alike is disruptive physicians, of whom there are nearly 20,000 in the United States, by conservative estimates. These are doctors who have mental health, addiction, burnout, and anger management problems, explain Leonard D. Goodstein, PhD, ABPP, and John Shufeldt, MD, JD, MBA, FACEP, in a fascinating article that looks at one disruptive doctor's assessment and successful remediation, including a discussion of the psychological tests used in the evaluation process.

The authors consider AMA and Joint Commission definitions of a disruptive doctor; surveys that measure the incidence and

impact of unruly physicians; the ripple effects of disruptive behavior on patients, staff, and urgent cares; the evaluation and remediation process,; and the role of the physician leader in solving the problem or abetting it. Also included is a directory of organizations—consulting firms, universities, hospitals, and state-run entities—that offer assessment and remediation services for disruptive physicians.

Dr. Goodstein, a clinical psychologist, is CEO of Professional Assessment Services and Solutions (PASS) in Scottsdale, Arizona, which offers assessment and remediation services for problem doctors. Dr. Shufeldt, an urgent care physician and attorney, is principal of Shufeldt Consulting, also in Scottsdale, and is a member of the Editorial Board of *JUCM*.

Also in this issue:

Nahum Kovalski, BSc, MDCM, reviews new abstracts on current literature germane to the urgent care clinician, including heparin-binding protein as a new biomarker for bacterial meningitis; a 20-year follow-up on a randomized prostate cancer screening trial; early initiation of hemodialysis; whether mandates reduce emergency department overcrowding; and new guidelines for treating painful diabetic neuropathy.

John Shufeldt, MD, JD, MBA, FACEP, takes an unusual approach to medical malpractice suits in his Health Law column this month. Instead of offering advice on how to avoid them, he offers advice on how to practically guarantee a doctor and an urgent care will be named in one—and end up losing big. His "four studies in self-destruction" make for eye-opening reading.

David Stern, MD, CPC, discusses whether 99283 and 99214 procedure codes can be used for an urgent care visit, whether modifier -25 can be appended to a surgical code, the use of S codes with Medicare patients, and the correct CPT code for a diagnosis of gastroenteritis with no other services rendered.

Our **Developing Data** end piece looks at urgent care physician compensation. Surprisingly, the greatest number of doctors by a significant margin are in the top compensation category. Check it out and see where you stand.

Erratum

In the June issue of *JUCM*, in a Case Report on acute pancreatitis, the patient's blood pressure was listed as 25/85. The correct blood pressure was 125/85. We regret the error. It has been corrected in the online edition of *JUCM*. ■

What You Missed at the Members Meeting Last May

LOU ELLEN HORWITZ, MA

It was great to see so many of you in Chicago for the Annual Convention! For those of you who couldn't join us, I wanted to be sure you knew what was discussed at the Members Meeting so everyone is aware of where UCAOA is headed.

As you probably know, the UCAOA Board of Directors also meets before the Convention begins (and also in the fall). The Board approved some new strategic directions that we were able to announce just a few days later at the Members Meeting.

The new strategies represent an expansion of focus for UCAOA. Heretofore, our primary focus had been directly on you: the center owners and the professionals who work in those centers. Our job has been to develop and share resources to help each of your individual centers be as successful as possible. That will continue to be a focus, and we will still be working to bring you the best education and resources available.

In addition to that job, we have come to understand from all of you that we need to also be working to help you collectively, as an industry, to be as successful as possible. This means some shifts in how we allocate our resources and staffing, and how we spend our time each day. While we have been doing some small advocacy projects over the years, we are going to ramp up those efforts significantly in the coming year.

Thanks to all of you, we have been successful enough as an association to now have the funds to expand our staff and tap into other outside experts to begin to leverage the collective voice we have all worked so hard to build over the past few years. The Board of Directors has approved several new hires, so we can allow our current staff to grow in their roles and bring you new and better programs, as well as bring in some entirely new talent to begin that industry advocacy in earnest.

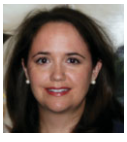
"While we have been doing some small advocacy projects over the years, we are going to ramp up those efforts significantly in the coming year."

This will not happen overnight, but we have already begun taking some steps in those directions, and you should start seeing some public effects of those steps very soon. We've joined some other national organizations, have begun commenting publicly on specific legislation, and the hiring processes have begun. We are also getting UCAOA's name out there by attending the national meetings of organizations where we have (or are) stakeholders: insurance organizations, ACO summits, and others. I'm re-starting the Executive Director blog this month to help keep everyone up to date on our efforts, so watch for an announcement about that electronically. There's a lot to tell you about!

A few other items of significance were decided at the Members Meeting that we are pleased to re-announce here. Two awards were presented : the Outstanding Achievement Award to Stu Williams and Peter Murphy, publishers of JUCM, for their contributions to the field of urgent care, and the Life Member Award to Dale Key, long-time Board member and Benchmarking Committee Chair, for his extensive contributions to UCAOA.

We are pleased to welcome two new members to the UCAOA Board of Directors. Dr. Roger Hicks and Mr. Steve Sellars were newly elected by the membership, and we welcome back re-elected Directors Dr. Peter Lamelas, Dr. Don Dillahunty, and Laurel Stoimenoff for a second term.

Finally, the Directors elected Dr. Marc Salzberg to be UCAOA's new President and Dr. Nathan Newman as Vice President. Laurel Stoimenoff and Cindi Lang will continue in their roles as Treasurer and Secretary, respectively. Sincere thanks to all of these individuals for making UCAOA what it is today. ■



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Clinical

Acute Stridor in Children

Urgent message: Acute stridor in pediatric patients is alarming to children, parents, and healthcare providers alike. Differential diagnosis is the key to initial evaluation and management of this worrisome symptom. Here is how to think it through.

JERRI A. ROSE, MD, FAAP

Introduction

Stridor is an externally audible sound caused by abnormal air passage during breathing.[1] It results from turbulent airflow through large airways. When a normal respiratory volume of air passes through narrowed airways, the normal laminar flow becomes turbulent. Therefore, stridor serves as a signal of partial airway obstruction.

Stridor occurs relatively commonly in pediatric patients. Its presence can be alarming to children, parents, and healthcare providers alike. Children presenting with stridor require a thorough and careful evaluation to determine the underlying cause of this worrisome symptom, and to promptly detect and address any life-threatening etiologies.

This article discusses differential diagnoses for acute stridor in children and offers guidance for the initial evaluation and management of children presenting acutely with stridor.

Pathophysiology

Stridor may be caused by pathology anywhere within the large airways, from the anterior nares to the subglottic region. The level of obstruction can be inferred based on the phase of respiration during which stridor occurs. Stridor arising from pathology in the extrathoracic region of the upper airway (including the nose, pharynx, larynx, and trachea) is more pronounced during inspiration, while stridor originating in the intrathoracic airways (tracheobronchial tree) is usually more prominent on exhalation. If upper airway obstruction at any level is critical and fixed, biphasic inspiratory and expiratory stridor can result. Of note, obstruction of the nares and nasopharynx generally results in low-pitched snoring or "snorting" sounds, often referred to as stertor.

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Categorizing Potential Causes for Stridor

Stridor in pediatric patients may occur due to a wide

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Table 1: Life-threatening Causes of Acute Stridor

Usually febrile	Usually afebrile
Bacterial tracheitis	Upper airway foreign body
Epiglottitis	Anaphylaxis
Retropharyngeal abscess	Hereditary angioedema
	Thermal or caustic injury
	Neck trauma
	Neoplasms

range of disease processes involving the large airways. In considering the differential diagnosis for stridor, it is helpful to "divide" potential causes based on whether the onset is acute or chronic.[1] This article focuses on the causes and management of *acute* stridor.

For stridor manifesting acutely, possible etiologies can be further divided into infectious (febrile) versus non-infectious (afebrile) causes. It must be emphasized that stridor can indicate life-threatening upper airway pathology; thus, life-threatening causes must be considered and addressed very early in the evaluation process (**Table 1**).

Causes of Acute Stridor in the Febrile Child

Differential diagnosis for stridor manifesting acutely in a febrile child includes croup, bacterial tracheitis, epiglottitis, retropharyngeal abscess, and peritonsillar abscess.

Croup

Viral laryngotracheitis (croup) is by far the most common cause of acute stridor in febrile children. Croup is a common childhood illness characterized by acute onset of rhinorrhea, fever, and a distinctive barky cough. It is typically accompanied by hoarseness, inspiratory stridor, and varying degrees of respiratory difficulty resulting from partial upper airway obstruction.

While many different viruses have been associated with croup, it is most commonly associated with parainfluenza type 1. Infection with respiratory viruses leads to generalized inflammation and mucosal edema in upper airway structures, including the larynx, trachea, and bronchi, accompanied by necrosis and shedding of mucosal epithelial cells. The anatomic hallmark of croup is tracheal narrowing due to mucosal edema in the subglottic region.

Croup primarily affects children between 6 months and 3 years of age, although it can occur in younger infants as well as in older children. Cases present throughout the year, but most occur in the fall and early winter months (September to December) in North America. Croup is generally a benign and self-limited illness with population-based studies demonstrating that less than 5% of patients require hospitalization.

Children with severe croup, however, may experience marked respiratory distress. Patients affected most severely may require admission to an intensive care setting and possibly even intubation or surgical airway management. Children with underlying narrowing of the upper airway structures at baseline (such as those with underlying subglottic stenosis from prior intubation) are at risk for significant upper airway obstruction from viral croup, as well as for experiencing recurrent bouts of croup.

The onset of croup in children may be quite frightening for families due to the unexpected and rather unusual presentation.[2] Symptom onset is typically abrupt and often happens at night, signaled by development of a harsh, barky cough and noisy breathing following a prodrome of non-specific upper respiratory symptoms. Symptoms increase in severity when children become agitated due to increased airflow turbulence. Children with croup are usually febrile (with temperatures most often ranging from 38 -39° C), but they do not drool or appear toxic.

Alternative etiologies should be considered if a child with stridor presents with drooling or toxic appearance. More than half of croup patients experience resolution of their cough and noisy breathing within 48 hours. A few, however, may display these symptoms for up to a week.

Croup is a clinical diagnosis. Children presenting with the classic signs and symptoms do not require further laboratory or imaging studies to confirm the diagnosis. In cases where the diagnosis is in question, a child's clinical course is atypical, an inhaled or ingested foreign body is suspected, a child is presenting with recurrent croup, and/or response to therapeutic measures does not occur as expected, plain radiographs of the neck soft tissues and/or chest may aid in confirming the diagnosis. In children with croup, an A-P radiograph of the neck and/or chest will reveal narrowing in the subglottic region, often referred to as the "steeple sign." A lateral neck radiograph in croup patients may show over-distention of the hypopharynx during inspiration and subglottic haziness.[9] The epiglottis should appear normal.

Bacterial tracheitis

Bacterial tracheitis can occur as a primary or secondary infection and may be confused with croup.[3] In primary

infections, children generally display acute onset of upper airway symptoms (which may include stridor, a painful cough, anterior neck pain, thick airway secretions, dysphagia, and drooling), along with high fever and a toxic appearance.

Secondary infections may rarely arise after acute viral respiratory tract infections, including croup. In cases of secondary infection, children may display symptoms of mild to moderate illness for a few days, followed by a worsening course with onset of high fevers, ill appearance, and increasing respiratory distress.

Children with bacterial tracheitis may develop thick, purulent tracheal exudates that contribute to upper airway obstruction along with concurrent airway inflammation and edema. *Staphylococcus aureus* is the most frequently isolated pathogen, though a number of other bacterial pathogens have been implicated.

Bacterial tracheitis should be considered as an etiology in any febrile child with acute stridor who displays a toxic appearance, dysphagia, drooling, or purulent upper airway secretions. Children with bacterial tracheitis do not respond as favorably to treatment with nebulized epinephrine as children with simple viral laryngotracheitis; this lack of clinical response thus serves as a further diagnostic clue.[4] Bacterial tracheitis management involves airway support and broad-spectrum intravenous antibiotic coverage including coverage for *S. aureus* (including methicillin-resistant *S. aureus*). The optimal antibiotic regimen for bacterial tracheitis has not been studied in randomized controlled trials. Some experts recommend that initial therapy include coverage for the most commonly isolated pathogens, which include *S. aureus*, group A streptococcus, *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Moraxella catarrhalis*.[10] Suggested broad-spectrum coverage for these organisms includes an anti-staphylococcal agent with coverage for *MRSA* (such as vancomycin or clindamycin) plus a third-generation cephalosporin.[10] Cultures of tracheal secretions should be obtained when possible so that the child's antibiotic regimen may be tailored as indicated.

Epiglottitis

Acute epiglottitis, an infection of the supraglottic airway structures, is a potentially life-threatening cause of acute stridor in febrile children. Once a relatively common pediatric respiratory emergency, the incidence of epiglottitis in children has plummeted to approximately 0.6 to 0.78 cases per 100,000 in the United States since introduction of the conjugate vaccine against *H. influenzae* type b (Hib), which caused the majority of cases.[6] Despite this dramatic decrease, cases of epiglottitis still occur, even in immunized children. Additional bacterial causes of epiglottitis include other types of *H. influenzae*, streptococci, and *S. aureus*.

Children with acute epiglottitis typically appear ill and present with sudden onset of high fever and rapid progression of dysphagia, drooling, and respiratory distress. Affected children generally do not have barking cough but can present with muffled speech, stridor, and a sensation of choking. To compensate for the airway obstruction caused by infection of supraglottic structures, epiglottitis patients may assume a "tripod" position, leaning forward with hyperextension of their necks and opening of their mouths.

Without treatment, epiglottitis can progress rapidly to cause life-threatening upper airway obstruction and respiratory arrest. Examination of children in whom epiglottitis is suspected should occur in a setting where the airway can be secured immediately, if necessary (ideally an operating room or intensive care setting, with personnel experienced in advanced airway management techniques readily available). Such children should be allowed to maintain their positions of comfort, and any interventions that might precipitate agitation should be avoided.

Soft-tissue neck radiographs can aid in confirming the diagnosis of epiglottitis, although they are unnecessary in many cases. The classic radiographic finding in epiglottitis is the "thumb sign," referring to the lateral view of the swollen epiglottis resembling the pad of a thumb. The thumb sign is subjective, however, and radiographs alone should not be used to rule out the diagnosis. Radiographs should be deferred if they will agitate the patient or delay definitive diagnosis and management. Children with suspected epiglottitis who need to be transported to the radiology department for imaging should be accompanied by a clinician skilled in airway management. If clinical suspicion is high, imaging should be deferred in favor of direct visualization of the airway under controlled circumstances.

Retropharyngeal abscess

A retropharyngeal abscess, which fills the potential space between the anterior border of the cervical vertebrae and the posterior esophageal wall, is another possible cause of acute stridor in the febrile child. These infections occur most commonly in children younger than 4 years and are usually caused by group A streptococci, anaerobic organisms, and *S. aureus*.

Children with retropharyngeal abscesses may develop a clinical picture similar to that seen with epiglottitis, with high fever, muffling of the voice, and a toxic appearance; onset is generally less abrupt, however. As purulent material collects in the retropharyngeal space, the abscess obstructs the larynx and esophagus, leading to stridor, voice changes, and drooling.[5] Other findings may include sore throat, neck pain (which may decrease neck movement), and cervical lymphadenopathy. Inflammation surrounding the abscess may lead to meningismus; as a result, a number of children with retropharyngeal abscesses have initially been diagnosed with meningitis.

A high index of suspicion must be maintained to accurately identify children with retropharyngeal abscesses. Noting a midline swelling of the posterior pharyngeal wall on examination may help make the diagnosis, but this finding is often difficult to observe in the ill, uncooperative child. If the diagnosis is suspected and the patient's airway is stable, a lateral neck radiograph and/or contrasted CT scan of the neck should be obtained to confirm the diagnosis. The lateral neck radiograph will show an increase in the width of the soft tissues anterior to the vertebrae and, occasionally, an air-fluid level. A neck CT will help to identify and localize any soft tissue swelling, and it will aid in localizing a retropharyngeal fluid collection. Definitive therapy for children with retropharyngeal abscesses involves intraoperative drainage and intravenous antibiotics to cover the common causative pathogens.

Peritonsillar Abscess

Peritonsillar abscess should be considered in children presenting with signs of upper airway obstruction, although most patients do *not* present with stridor. Peritonsillar abscesses typically affect adolescents. They are the most common deep infections of the head and neck, usually arising as a complication of bacterial tonsillitis. Pathogens most commonly isolated from these lesions are Group A streptococci, various anaerobic organisms, and occasionally *S. aureus*.

The findings of trismus, difficulty speaking, and drooling help to separate children with peritonsillar abscesses from those with simple pharyngitis, which is far more common. Examination of affected patients reveals pharyngeal erythema with unilateral tonsillar swelling, which often causes displacement of the uvula toward the unaffected side.[5] The examiner may be able to palpate a fluctuant mass intra-orally. Reactive cervical adenopathy is also commonly seen.

Peritonsillar abscesses are generally apparent on physical examination; therefore, imaging is not required to confirm the diagnosis. Most patients require admission for drainage, intravenous antibiotics, pain control, and intravenous hydration.[5]

Causes of Acute Stridor in the Afebrile Child

Differential diagnosis for stridor manifesting acutely in an afebrile child includes upper airway foreign body, thermal or caustic injury, spasmodic croup, anaphylaxis, hereditary angioedema, trauma, neoplasms causing airway compression, and psychogenic stridor.

Upper airway foreign body

Foreign body aspiration is a relatively common and potentially life-threatening etiology of acute stridor in afebrile children. The majority of cases occur in children younger than 3 years, with the peak incidence between 1 and 2 years of age. At this age, most children can walk, have the fine motor skills to place small objects into their mouths, and possess the developmentally normal tendency to explore their world via the oral route; however, they lack the dentition to chew food adequately and the respiratory effort to clear an aspirated object.[7]

Young children are at highest risk for significant airway obstruction from aspirated foreign bodies because of their small airway diameters. In older children, neurodevelopmental disorders, impaired level of consciousness, and substance abuse increase the risk of foreign body aspiration. Food items—including nuts, seeds, popcorn, and hot dog pieces—are the most common items aspirated by infants and toddlers. Non-food items—such as coins, pen caps, paper clips, and small toys—are more commonly aspirated by older children.

The presentation of foreign body aspiration varies, depending on whether the event was witnessed by a caregiver, the patient's age, the size and type of object aspirated, degree of resulting airway obstruction, and the object's location within the tracheobronchial tree.[7] Swallowed foreign bodies that become lodged in the esophagus may also cause stridor and other respiratory symptoms due to compression of adjacent upper airway structures.

Children presenting with abrupt onset of complete upper airway obstruction with severe respiratory distress, cyanosis, and altered mental status have a true airway emergency that mandates rapid recognition of the problem, life support, and immediate removal of the foreign body.[7] In less emergent situations (which, fortunately,

are much more common), physical examination may reveal stridor, localized wheeze, increased work of breathing, cough, decreased breath sounds, and/or hemoptysis.

Clinicians in the urgent care setting should maintain a high index of suspicion for foreign body aspiration in afebrile children presenting with sudden onset of stridor without preceding symptoms of illness. Caregivers should be directly questioned about any history of choking, as well as about the child's activities (ie, playing with toys, eating, unsupervised activity) prior to the onset of symptoms. While toddler-aged children are at highest risk for foreign body aspiration, non-ambulatory children may aspirate small objects placed inadvertently into their immediate surroundings or offered to them by older siblings; this possibility should be explored during the history-gathering process as well.

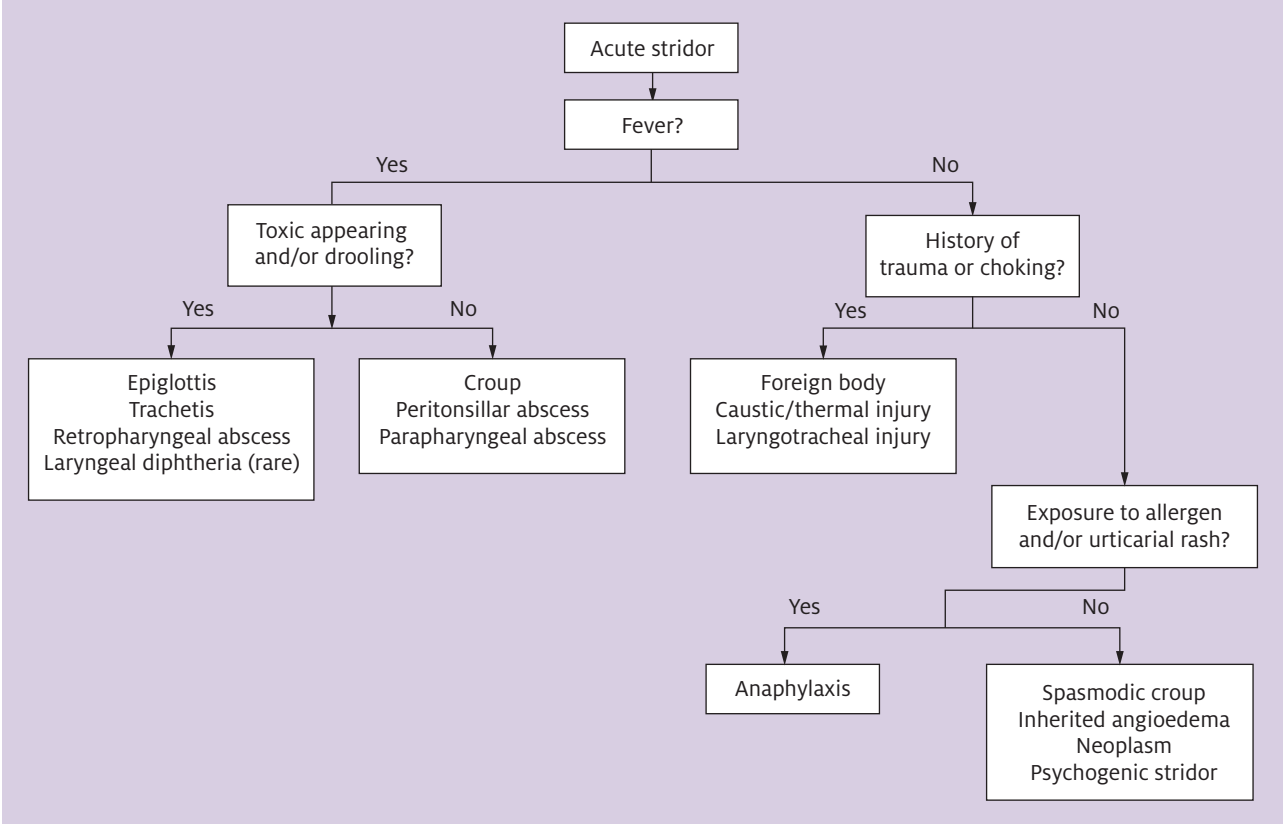
Plain radiographs of the neck and/or chest may or not be helpful in establishing the diagnosis of foreign body aspiration, depending on whether the object is radiopaque and whether airway obstruction is present. The majority of objects aspirated by children are radiolucent (food particles, plastic objects), and are not detected with plain radiographs. Therefore, a normal chest radiograph cannot rule out foreign body aspiration.

In children with suggestive presentations but normal standard chest radiographs, an expiratory chest radiograph (or lateral decubitus radiograph for younger children) or fluoroscopy may be helpful. If foreign body aspiration is highly suspected clinically, with or without confirmation by radiographs, bronchoscopic evaluation of the child's tracheobronchial tree should be arranged. Rigid bronchoscopy is the ultimate diagnostic tool for foreign body aspiration and is almost always successful in removal of aspirated objects.

Thermal or caustic injury

Both ingestion and inhalation of caustic or thermally damaging substances may result in injury to upper airway structures and result in stridor. This diagnosis should be considered in any child developing stridor following exposure to a hot or caustic substance.[5] Cases of thermal epiglottitis caused by swallowing scalding hot fluids or foods are rare but have been reported in the literature. Symptoms of airway compromise may present up to several hours after an offending exposure. Any child with evidence of significant and/or rapidly progressive upper airway obstruction from a thermal or caustic injury should undergo immediate endotracheal

Figure 1. Diagnostic approach to children with acute stridor.



intubation. Delay in securing a definitive airway will only permit further development of airway edema and increase the difficulty of securing the airway.

Spasmodic croup

Spasmodic croup is a variant of croup that lacks the typical viral prodrome (runny nose, low-grade fever). Symptoms start suddenly, often in the middle of the night, and resolve quickly. Symptoms may recur for several nights in a row. The etiology of spasmodic croup is unknown.

Anaphylaxis

Sudden onset of stridor in an afebrile child without associated trauma or choking, especially in the presence of urticaria, facial swelling, pruritus, and/or wheezing, suggests upper airway obstruction resulting from anaphylaxis. This diagnosis may be suggested by history of exposure to an offending allergen prior to symptom onset. Patients with this clinical picture should receive immediate airway, breathing, and circulatory support in conjunction with prompt administration of intramuscular epinephrine and antihistamines.[5] The addition of corticosteroids should also be considered. Children presenting with anaphylaxis should be admitted to the hospital for further observation and management.

Hereditary angioedema

Though rare, hereditary angioedema may present in childhood, and exacerbations may cause acute stridor secondary to laryngeal edema. Patients often have a family history of this condition. Attacks can result in painless swelling of the upper airway, extremities, face, and/or genitalia that is not associated with urticaria. Although a new medication is available to correct the underlying deficiency of C1 esterase inhibitor in hereditary angioedema patients, fresh frozen plasma may also be used to treat acute attacks.

Trauma

Blunt or penetrating trauma to the neck may result in mucosal lacerations, laryngeal or tracheal hematomas, vocal cord paralysis, or fractures of the thyroid and cricoid cartilages.[1] Patients with traumatic injuries to upper airway structures often present with varying

degrees of neck pain, stridor, hoarseness, hemoptysis, and respiratory distress. Physical examination of children with blunt trauma may reveal anterior neck tenderness, crepitus, tracheal deviation, and absence of the normal prominence of the thyroid cartilage. Proper treatment of upper airway injuries requires prompt recognition and stabilization of the airway. For children with suspected upper airway injuries, an otolaryngologist or similarly skilled specialist may be needed to evaluate the upper airway structures and to intervene with intubation, establishment of a surgical airway, and/or definitive surgical management of any injuries present. Children with penetrating neck injuries may require angiography or magnetic resonance imaging (MRA/MRV) to evaluate for potential vascular injury.

Neoplasms Causing Airway Compression

Mediastinal neoplasms may present with respiratory symptoms, including stridor, secondary to airway obstruction or erosion. At least one-third of all mediastinal masses occur in children younger than 15 years of age. Patients may display cough, wheezing, recurrent respiratory infections, hemoptysis, chest pain, and even syncope or sudden death. Children with neoplasms impacting the airway should be hospitalized to undergo urgent evaluation, as these tumors and their associated mass effect may be potentially life-threatening.

Psychogenic stridor

Though uncommon, psychogenic stridor may be a potential etiology of acute stridor in older children. Most cases have been reported in adolescents, with girls diagnosed more commonly than boys. Many children with psychogenic stridor meet diagnostic criteria for another psychiatric disorder. Patients typically display stridor that manifests acutely, but without the expected amount of associated respiratory distress. The stridor may be triggered by a distressing event and characteristically improves when the patient is unaware of being observed. Diagnosis may be confirmed by direct laryngoscopy in the symptomatic child, which reveals vocal cord adduction during inspiration.

Evaluation and Management of Acute Stridor

The initial priority in evaluating and managing any child presenting with acute stridor is ensuring the adequacy of the airway, breathing, and circulation and promptly instituting resuscitative measures as necessary. Once the ABC's are determined to be adequate and stable, further evaluation and treatment may continue in a systematic fashion (**Figure 1**).

Because stridor serves as a sign of partial upper airway obstruction and can arise from life-threatening causes, children with stridor should be approached as gently as possible to avoid agitation, particularly during the early stages of evaluation while airway adequacy is being ascertained. Young children should be allowed to stay with their caregivers, and all patients should be allowed to remain in their preferred positions of comfort.

Interventions causing agitation in the stridorous child may lead to further airway compromise and/or worsening respiratory distress. During the initial assessment of a child with stridor, the clinician should note the child's position of comfort and ease of movement; reluctance of the child to move out of a certain position may serve as a "red flag" of significant upper airway obstruction. For example, a child with significant upper airway obstruction may hyperextend his or her neck and lean forward to straighten the upper airway and maximize air entry ("sniffing position"). If such a finding is noted, the child should be kept as calm as possible in his or her preferred position until a clinician skilled in airway management is present and preparations have been made to secure the child's airway in a controlled manner, if necessary.

As with all other pediatric complaints, a history and physical examination are invaluable aids in identifying the underlying cause for stridor. For children with acute stridor, the history should focus on associated symptoms such as fever, duration of illness, change in voice, drooling, rhinorrhea, cough, urticaria, and any history of choking. Immunization status should be verified, especially vaccination against Hib.

In addition to a careful respiratory examination focusing on adequacy of air movement and the child's work of breathing, the physical examination should include inspection of the nares and oropharynx, with particular attention to increased secretions, drooling, uvular deviation, visible bulging/masses, and abnormal phonation. Regional findings such as adenopathy, neck masses, meningismus, bruising, and other evidence of trauma should also be noted. As noted earlier in the section on pathophysiology, several characteristics of stridor—including its pitch, length of respiratory phase, and associated phase of respiration—can aid in determining the level of airway obstruction.

Emergency management of children with acute stridor depends on the underlying etiology and degree of associated respiratory compromise. Recommended strategies for management of various pathologies caus-

ing stridor were briefly discussed earlier. A more in-depth discussion of two common pediatric conditions causing acute stridor—croup and foreign body aspiration—is provided here.

Management of Acute Laryngotracheitis (Croup)

Most children with croup can be managed successfully as outpatients. Three major goals for acute croup therapy are to decrease airway inflammation and edema, provide respiratory support, and maintain adequate hydration.

The mainstays of acute croup management are corticosteroids and nebulized epinephrine. Corticosteroids have a well-established history of use in children with croup, with clear evidence for their effectiveness.[2] A compilation of clinical trial data reveals significant benefits for croup patients treated with corticosteroids, including decreased clinical croup scores, lower risk of intubation, and reduced duration of symptoms, even in patients with mild illness. The standard recommended corticosteroid regimen for children with croup is single-dose dexamethasone 0.6 mg/kg, which may be given orally, intramuscularly, or intravenously. Repeat corticosteroid doses have no proven benefit for croup patients and are not routinely recommended.

Treatment of children with moderate to severe croup with nebulized epinephrine has been well-studied and found to reduce clinical croup severity and the need for invasive airway support.[2] Thus, nebulized epinephrine is recommended for patients with moderate to severe croup, including those with stridor at rest and moderate to severe retractions. Racemic epinephrine has traditionally been utilized in croup management, but L-epinephrine 1:1,000 is as effective and safe. In most studies, the standard nebulized epinephrine dose used in children of all ages is 0.5 mL of 2.25% racemic epinephrine solution, or 5 mL of 1:1,000 L-epinephrine. Children demonstrating clinical improvement after administration of nebulized epinephrine must be observed for a minimum of 2-3 hours in the urgent care setting for occurrence of the "rebound phenomenon"—the tendency for patients' symptoms to return as the effects of epinephrine wear off.

If the urgent care facility is unable to provide necessary observation, then transfer to an emergency facility should be initiated. The decision for patient transfer, however, should not delay initiation of treatment. The urgent care setting should therefore be comfortable with the administration of nebulized epinephrine, when indicated.

Those children failing to improve clinically after administration of nebulized epinephrine—or demonstrating recurrence of moderate to severe symptoms during their periods of observation—should be hospitalized.

Management of Foreign Body Aspiration

For any child presenting with complete obstruction of the upper airway by a foreign body, dislodgement of the object should be attempted using alternating cycles of back blows and chest compressions in infants, and abdominal thrusts in older children in accordance with the American Heart Association (AHA) guidelines.[8] These maneuvers should not be used in children who are able to cough or speak as they may worsen the degree of airway obstruction. The use of "blind" mouth sweeps in an attempt to remove an aspirated object should also be avoided.

For children who become unresponsive despite dislodgement attempts, CPR beginning with chest compressions should be instituted immediately according to AHA guidelines.[8] Emergent subspecialist consultation for removal of the foreign body by rigid bronchoscopy should be obtained. Endotracheal intubation may allow some ventilation until rigid bronchoscopy is possible, and oxygen and other basic life support measures should be provided until the obstruction can be relieved.[7] If a foreign body is apparent to the urgent care clinician on visualization of the mouth or upper airway, forceps may be used to remove the object.

For stable children with suspected foreign body aspiration or ingestion, radiographic studies may be obtained to help confirm the diagnosis. Those in whom the diagnosis is highly suspect should undergo rigid bronchoscopy to identify and remove the foreign object. ■

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Dealing with the Disruptive Doctor

Urgent message: When a physician is dubbed "Tom the Terror," turning a blind eye can send patients and staff heading for the exit, wreck your reputation, and spark a lawsuit. Here's what to do instead.

LEONARD D. GOODSTEIN, PHD, ABPP, and JOHN SHUFELDT, MD, JD, MBA, FACEP

Introduction

Tom P. is a competent, board-certified emergency physician. He is liked and respected by his patients. But Tom's relationships with staffers at the urgent care center where he still works used to be another matter entirely. His medical colleagues were treated with haughty disdain. With office staff, nurses, and techs, he was demanding, caustic, and dismissive. At the least provocation, he would fly off the handle. One time, he opened the supply cabinet, found his favorite pens out of stock, and threw a tantrum in the back office, excoriating the office manager in front of her shocked and appalled staff.

Some staffers complained to Phil R., the center medical director. However, like many physicians in supervisory positions, Phil was reluctant to intervene. When he finally did mention the complaints, Tom brushed them off—and Phil let him, naively hoping that Tom would come to his senses on his own.

Instead, Tom's relationships at the clinic continued to deteriorate. Staffers dubbed him "The Terror" and tried to arrange their work schedules so as not to overlap with his. After Tom exploded at a physician assistant, a group of staffers confronted Phil: unless Tom's behavior changed, they would resign en masse.

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Phil then confronted Tom. Tom dismissed the complaints. Except for a few malcontents, he insisted, his relations with the staff were fine. Now it was Phil's turn to insist that Tom needed to get help. Tom was referred for psychological evaluation and possible intervention.

When Is a Physician "Officially" Disruptive?

There is no universally accepted definition of a disruptive physician. Over a decade ago, the AMA defined a disruptive physician as a doctor whose behavior "interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care."[1,2] Note that this definition focuses on the overt behavior of the physician and the impact of this behav-

ior on patients and the health system in which the physician works. Given the simplicity, clarity, and broadness of this definition, identifying physicians who meet these criteria should be relatively easy.

Among the categories of behavior that could result in disruptiveness are overt psychosis, clinical depression, drug or alcohol abuse or addiction, personality disorders, excessive stress and burnout, and behavioral changes due to aging. Within these categories, examples of disruptive behavior include disrespectful and profane language; angry outbursts; threats; inappropriate criticism of care given by other professionals; sexual harassment; drunkenness; throwing objects (eg, scalpels, clamps, clipboards) at staffers; failure to observe patient/physician boundaries; failure to respond to calls while on duty; failure to show up punctually for work; unauthorized absences during the workday (eg, long lunches, habitually leaving early); and unkempt, disheveled, or otherwise unprofessional appearance.

By displaying inappropriate emotions and uncollaborative behavior in the workplace, disruptive physicians jeopardize the provision of quality healthcare. The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO) mandates that each healthcare delivery system must "have a code of conduct that defines acceptable, disruptive, and inappropriate behavior." In addition, each system must "create and implement a process for managing disruptive and inappropriate behaviors."[3] We will consider this process in a moment.

How Common Are Unruly Doctors?

Sound, research-based data on the incidence of disruptive physicians does not exist. Based on a survey of the extant literature, Leape and Fromson conclude that 3%-5% of all physicians evince problematic disruptive behavior.[4] In another literature review, Williams arrives at a significantly higher estimate: 6%-12% of physicians are "dyscompetent"—that is, not performing at an acceptable standard for providing patient care.[5] Unfortunately, Williams' analysis does not differentiate disruptive behavior arising from psychological problems and disruptive behavior resulting from lack of necessary knowledge and skill. A relatively large-scale study of physicians, nurses, and administrators at 102 Veteran's Administration hospitals concluded that 1%-3% of physicians display serious disruptive behavior.[6]

These estimates do not suggest an epidemic, so it is easy to conclude that the problem of disruptive physicians is a tempest in a teapot. Not so. According to the Bureau of Labor Statistics, physicians and surgeons held approximately 661,400 jobs in 2008 (the latest year for which statistics are available).[7] If only 3% of those doctors are disruptive, that means 19,842 physicians in the United States are behaving like Tom—or worse.

The Ripple Effects of Disruptive Behavior

The ripple effects of their unruly behavior adversely impact a far wider circle of people than the doctors in question. More than two-thirds of the respondents in the VA hospitals study, for example, had witnessed physicians engaging in disruptive behavior and reported that such behavior led to medical errors in 71% of the cases and patient mortality in 27%.[6]

A 2011 survey of a group of hospital emergency departments found that more than half the respondents (57%) had observed disruptive behavior in physicians.[8] One-third of the respondents felt that disruptive behavior could be linked to the occurrence of adverse events, 34.5% to medical errors, 24.7% to compromises in patient safety, 35.8% to poor quality, and 12.3% to patient mortality. Disruptive behaviors "have a significant impact on team dynamics, communication efficiency, information flow, and task accountability," the authors write, "all of which can adversely impact patient care."

While studies of disruptive physicians have primarily been conducted in hospital settings, problem doctors pose significant risks to any healthcare organization—including urgent cares—in patient safety, quality of care, staff morale, and community confidence and support, not to mention the potential for lawsuits brought by patients or even members of a clinic's staff. Failure to deal promptly and effectively with an unruly doctor undermines staff confidence in the center's leadership and sends a tacit message: "No one here seems to care about how we treat patients, so why should I?" Once allowed to take root, such permissiveness can quickly permeate and undermine a clinic's culture.

Problem doctors severely reduce the job satisfaction of nursing and ancillary staff, further lowering morale and increasing staff turnover.[6] Williams and Williams found that a disruptive team member leads not only to decreased morale of other team members but also reduces their commitment to the profession and to the workplace.[9] This is something that no healthcare facility in a competitive market environment can afford.

Lawsuits Waiting to Happen

The financial risks posed by disruptive physicians are

substantial. Medical errors caused by problem doctors that have direct adverse consequences for patients open the door to malpractice litigation and negative financial impact on an urgent care. When those consequences cause patient morbidity and mortality, the potential negative financial impact is even greater.

In many cases, insurance coverage may defray most, if not all, of a financial settlement. However, the costs in staff time, energy, and stress in preparing for and defending against such litigation will not be mitigated. And when the litigation results in a large settlement against a center, the negative publicity hurts its reputation in the community.

An urgent care also faces substantial financial risks when such behavior is directed at staff members. Imagine if a doctor like Tom had verbally attacked a nurse while absentmindedly holding a scalpel, frightening but not actually physically injuring her, and she subsequently sued the center and scalpel-wielding doctor for damages, citing post-traumatic stress disorder.

While it is difficult to predict how a judge or jury would respond in such a case, how the center had dealt with previous complaints about the disruptive physician would be critical to its defense. If such complaints had been ignored or handled with a perfunctory wrist slap, the center would likely be seen as complicit in tolerating such behavior and could be liable for a portion of the damages, which typically are not covered by malpractice insurance.

If, on the other hand, the problem doctor had been warned about the seriousness of his behavior, had been urged to begin a remedial course of action, and a record of this feedback was carefully recorded and maintained, the outcome would likely be very different.

Medical Culture's Feedback Problem

Despite profound changes in medical organization and practice, medical training—and the underlying culture of which it is an expression—remain largely stuck in yesterday's paradigm of care delivery. In this model, each doctor is trained to function independently rather than collaboratively.

But treatment of patients is rapidly shifting from individual doctors making autonomous decisions to teams that include multiple physician and non-physician members who coordinate care as a group. The group, not the individual doctor, is increasingly accountable for the quality of that care. (And team members will increasingly sink or swim financially based on their ability to collaborate effectively.)

For this model to succeed, however, feedback is essential. Yet physicians are not acculturated to give and receive feedback. When a colleague is alcoholic, clinically depressed, anger-prone, or erratic in behavior, there is no politically correct way to intervene—until, that is, the inevitable but preventable catastrophe that everyone knew was in the offing finally makes it impossible not to intercede.

This reticence to speak up needs to end. For teams to work, disruptive conduct by any member must to be addressed with far greater swiftness, decisiveness, and skill than is now generally the case. That starts with feedback. Medical culture must evolve so that it becomes permissible to offer it.

Evaluation and Remediation of Problem Doctors

A number of organizations exist to assess disruptive physicians and offer coaching, counseling, workshops, seminars, and psychotherapy with the goal of behavior modification and reintegration into the workplace (see *Where to Seek Help* on page 20). Some are private consulting firms. Others are universities and hospitals. Still others are state-funded entities.

At Phil's behest, for example, Tom contacted a private firm specializing in the assessment and remediation of disruptive physicians. Three well-validated personality assessment tests, plus an in-depth clinical interview, were then used to develop a comprehensive psychological profile of Tom and clarify the nature of his problems (see *The Evaluation Process* on page 22). Tom took two of the tests online in a monitored setting. Monitoring was about to become a big part of his life.

Tom was initially resistant to the evaluation process. But it slowly began to sink in that his career was on the line. He could participate or not, but he would have to live with the consequences of non-participation. That would very likely mean he would, yet again, need to find another job. Once he understood the seriousness of his situation, he quickly became engaged in the process.

The clinical interview was revealing. Tom had always excelled in school and at sports. He did everything well. His parents were supportive; he was never criticized by them, even though he was criticized by others.

Breezing through medical school, Tom encountered his first problems during his residency. He found it difficult to follow the rules, preferring to do it "my way," raising serious questions in the eyes of others about his fitness for a medical career.

He took a year off to find himself, traveling and doing locums work. There were fewer rules. He experienced greater freedom from supervision. Ultimately,

Where to Seek Help

A number of organizations—consulting firms, universities, hospitals, and state-run entities—offer assessment and remediation services for disruptive physicians. Here is a sampling:

Anderson & Anderson
Offers a 12-hour coaching program with six months of aftercare for disruptive physicians.

Location: Brentwood, California
Phone: (310) 207-3591
Website: *www.andersonservices.com*
Email: *Georgeanderson@aol.com*

Center for Professional Health
Offers a three-day continuing medical education (CME) course for "distressed" physicians.

Location: Vanderbilt University Medical Center, Nashville, Tennessee
Phone: (615) 936-0678
Website: *www.mc.vanderbilt.edu*
Email: *cph@vanderbilt.edu*

Federation of State Physician Health Programs
Serves as an education resource on physician impairment for physician health programs (PHPs), which exist in all 50 states to help physicians address chemical dependency and mental health issues. Includes a directory of PHPs nationwide.

Location: Chicago, Illinois
Phone: (518) 439-0626
Website: *www.fsphp.org*
Email: *doughj@albmed.org*

Physician Assessment and Clinical Education Program
Offers a three-day CME "Anger Management for Healthcare Professionals Program," as well as assessment and monitoring services.

Location: University of California, San Diego
Phone: (619) 543-6770
Website: *www.paceprogram.ucsd.edu*
Email: *upace@ucsd.edu*

Physicians Development Program
Offers "People Skills" and "Physician Workplace" programs for problem doctors.

Location: Miami, Florida
Phone: (305) 285-8900, ext. 575
Website: *www.physiciansdevelopmentprogram.com*
Email: *info@pdpflorida.com*

Pine Grove Behavioral Health and Addiction Services
Offers a "Professional Enhancement Program" for professionals with addictive illness, disruptive behavior, boundary violations, personality disorders, interpersonal difficulties, and vocational issues.

Location: Hattiesburg, Mississippi
Phone: (888) 574-4673
Website: *www.pinegrovetreatment.com*
Email: *phemphill@forrestgeneral.com*

Professional Assessment Services & Solutions (PASS)
Offers intensive outpatient assessment, consultation, and treatment services for disruptive physicians.

Location: Scottsdale, Arizona
Phone: (602) 370-0303
Website: *www.passusa.org*
Email: *info@passusua.org*

Professional Renewal Center
Offers a three-day CME program for distressed physicians, assessment, monitoring, and more.

Location: Lawrence, Kansas
Phone: (877) 978-4772
Website: *www.prckansas.org*
Email: *eherrman@prckansas.org*

though, he returned and finished his residency. Finding a job was never a challenge. Tom was articulate, initially personable, and clearly bright. He had worked in several different emergency departments and urgent care centers before moving to his present job, always leaving when he found himself at odds with management.

As part of his evaluation, Tom was asked to choose six coworkers to offer feedback on his behavior. Phil was also asked to choose six respondents who knew Tom. The purpose was to let Tom see himself through the eyes

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The Evaluation Process

When a disruptive physician is sent for psychological evaluation, what is involved? While every assessment organization has its own way of doing things, three assessment instruments are in common use: a 360° Peer-Feedback Survey Instrument, the Minnesota Multiphasic Personality Instrument 2 (MMPI-2), and the Hogan Development Survey (HDS). In addition, there is an in-depth clinical interview. Each offers different kinds of information about the doctor under review..

The 360° Survey

The term "360° appraisal" originated in the business world and refers to *full circle* feedback from bosses, peers, more junior colleagues, and often customers. This approach evolved as the limitations of the more traditional top-down approach to evaluation became apparent—namely, that it was perceived as potentially unfair, biased, limited to one person's perspective, and often de-motivating. Because the 360° method overcomes such problems, it has been introduced in some hospitals, where it is typically used to provide feedback to residents.

In the case of a disruptive physician, a 360° Survey is used to collect data from medical colleagues, nurses, technicians, administrative staff, and others who interact regularly with the doctor being assessed. Using multiple sources to appraise physicians on multiple dimensions of functionality improves the objectivity and impact of the feedback. It is, furthermore, more difficult to discount the views of substantial groups of colleagues and subordinates than the views of just one or two.

MMPI-2

MMPI-2 is the oldest comprehensive psychological test designed to assess psychopathology. A self-report test, it has been standardized on thousands of subjects and provides objective indications of significant psychological disorders. It is designed to measure enduring characteristics—the relatively stable components of personality—more than the short-term fluctuations that vary with situational distress.

MMPI-2 not only measures psychopathology; it includes indices of validity that allow the interpreter to make assessments about the subject's test-taking biases. Those assessments include whether an individual is capable of understanding the test items, answering randomly, or attempting to minimize or amplify his symptoms. The current edition of the MMPI-2 includes several new scales that not only increase its validity but also provide better data for identifying serious psychopathology.

HDS

Based on well-validated research from the Center for Creative Leadership, an education and research organization, HDS is a self-report survey on factors leading to "derailment," causing an apparently successful career to go off-track.

In contrast to MMPI-2, which seeks to identify disabling psychopathology, HDS identifies the less-obvious personality disorders, the more subtle idiosyncrasies that end up becoming dysfunctional over time, particularly when the external controls on an individual's behavior diminish.

These dysfunctional behaviors typically are caused by people's distorted beliefs about how others will treat them, beliefs that negatively impact a person's career and life satisfaction. Such individuals are often are unaware that their perceptions are distorted or that their behavior has any negative impact. HDS is thus a very useful instrument for bringing these issues into the awareness that is an essential precursor for behavior change.

The Clinical Interview

The clinical interview includes a review of a physician's family background, early history, education, and work history, including problems encountered with work, marriage, and family. If coworker feedback is part of the assessment, it would be discussed at this time, as would the results of assessment tests; any critical items identified by test protocols would be examined in some depth. Based on these findings and the doctor's response to them, therapeutic recommendations would then be offered.

of others. Naturally, he chose people he believed understood and empathized with him.

No matter. The results were unanimous. All 12 respondents found much of Tom's behavior unacceptable, and there was an enormous gap between Tom's self-ratings, all highly positive, and those of the respondents, whose comments were not only quite negative, there was no discernable difference among them. Everyone felt that Tom was a bully and jerk!

Tom was shocked.

Tom was also given a comprehensive psychological test designed to assess psychopathology. The results showed no evidence of serious mental illness, although there was a strong suggestion of anti-social attitudes and behaviors. A self-report survey was also revealing. Tom's scores indicated that he had a narcissistic personality with a high degree of suppressed anger.

This feedback, interestingly, did not come as news.

"I've often wondered if I was a narcissist," Tom reflected. "My wife certainly won't be surprised to learn that she's been right about me all along."

The results of his evaluation were sobering. Tom enjoyed his clinical work and the lifestyle of an emergency and urgent care physician. The prospect of being forced to leave yet another job because of his anger management issues was disconcerting to him. He needed a reality check. He got one. Discussing a treatment regime was then no longer out of the question.

Phil received a report summarizing the findings. It is standard practice to keep the medical director, lead physician, or whoever refers a disruptive doctor for evaluation in the loop. A doctor under evaluation consents to this at the outset of the process.

The firm that assessed Tom then assigned him an affiliated psychotherapist, who would work with him for a period of two years. The therapist would also monitor Tom and send the assessment firm regular reports on his progress, which in turn would be summarized for Phil. Tom agreed to all this.

By the end of the first year, however, Tom was no longer "The Terror." He didn't suddenly become warm and cuddly, but least he now was able to maintain a professional demeanor with his coworkers. The outbursts ceased. Continuing follow-up provided both the guidance and feedback he needed to develop the necessary auto-control system that led to a successful outcome.

The Role of the Physician Leader

Disruptive physicians are often about two problem doctors, not one. The first is Tom, or someone like him. Then there's Phil. By putting off dealing with Tom, Phil was, in effect, his enabler. Why did he ignore repeated staff complaints? Why did people have to threaten to quit before he would act?

The Joint Commission's mandate is explicit: disruptive physicians should be dealt with decisively and in a timely manner. Every healthcare executive knows this—or should. Yet Phil's procrastination seems to be the rule rather than the exception with doctors with supervisory oversight of other doctors.

By doing, eventually, what he *should* have done—paying attention to staff complaints, then referring Tom for assessment and treatment—Phil never had to deal with the question of what *must* be done. But what if a disruptive physician refuses treatment, or refuses to acknowledge the validity of his assessment, or refuses to be monitored? What if he agrees to everything but his behavior doesn't change—or change enough?

In any of these events, there would be little or no alternative to terminating the doctor for cause. Not to do so would expose the center to litigation and potential serious financial risk. If the staffers who threatened to quit en masse had actually done so, it would have been disastrous for clinic, and morale among the staffers who remained would surely have been jeopardized. In addition, the center's reputation in the community would likely be harmed as word unpreventably spread.

Quality care, especially patient safety, necessitates that all caregivers behave in a professional manner, especially when engaged in direct patient care. This requirement is especially true for physicians, who tend to be viewed by non-physician staffers as team captains and setters of standards.

Healthcare organizations need to have unambiguous, clearly written policies and standards that clarify the meaning of "professional demeanor." Explicit expectations about being on time, manner of dress, answering calls—behaviors that in the "good old days" never needed to be mentioned—can no longer be assumed; they must be spelled out.

Physician executives with direct supervisory authority over other doctors must insist that these standards be met, and be ready to step in as enforcers of appropriate behavior before members of the center staff are driven to the point where they must threaten to quit. It may not be easy (see *Medical Culture's Feedback Problem* on page 19), but to allow a problem doctor to go unchecked is a dereliction of duty to all concerned: patients, staff, and the center itself. ■

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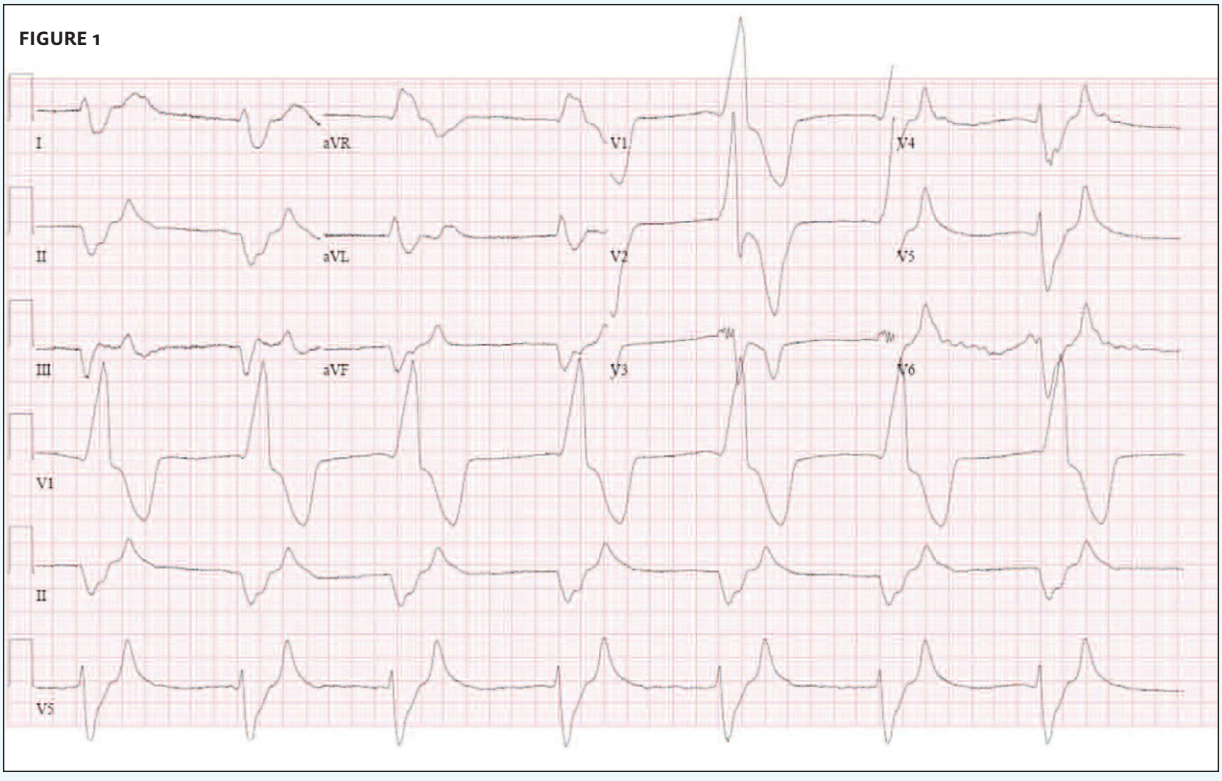
INSIGHTS IN IMAGE

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

FIGURE 1



The patient is a 37-year-old female who presents with a history of long-standing hypertension and diabetes mellitus. She had recently started on a new diuretic and felt very weak and light-headed.

Her blood pressure was 88/56 mmHg with a pulse of 44 beats per minute.

View the patient's ECG (**Figure 1**). Consider the type of diuretic is she likely to be taking and what your next steps would be.

Resolution of the case is described on the next page.

Peer Reviewers Needed

Each clinical cover article in *JUCM* is peer-reviewed by three physicians expert in the subject.

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INSIGHTS IN IMAGES

This ECG is highly suggestive of severe hyperkalemia, based on the loss of P waves, tall and widened T waves, and grossly prolonged QRS duration (often described as a "sine wave").

Most cases of significant hyperkalemia are due to underlying renal insufficiency, with potassium levels increased by tissue breakdown (eg, rhabdomyolysis), certain medications (eg, potassium-sparing diuretics), or occasionally hormonal deficiency (eg, adrenal insufficiency).

Symptoms of severe hyperkalemia include fatigue, weakness, nausea, heart failure, and various cardiac arrhythmias.

This patient was recently started on spironolactone and had a serum potassium of 8.6 mEq/L.

Treatment of symptomatic hyperkalemia should begin when there is reasonable clinical suspicion, as serum measurements may be delayed. While availability of agents may be limited in the urgent care setting, the following should be considered, when available, for immediate treatment while awaiting transfer to the ED:

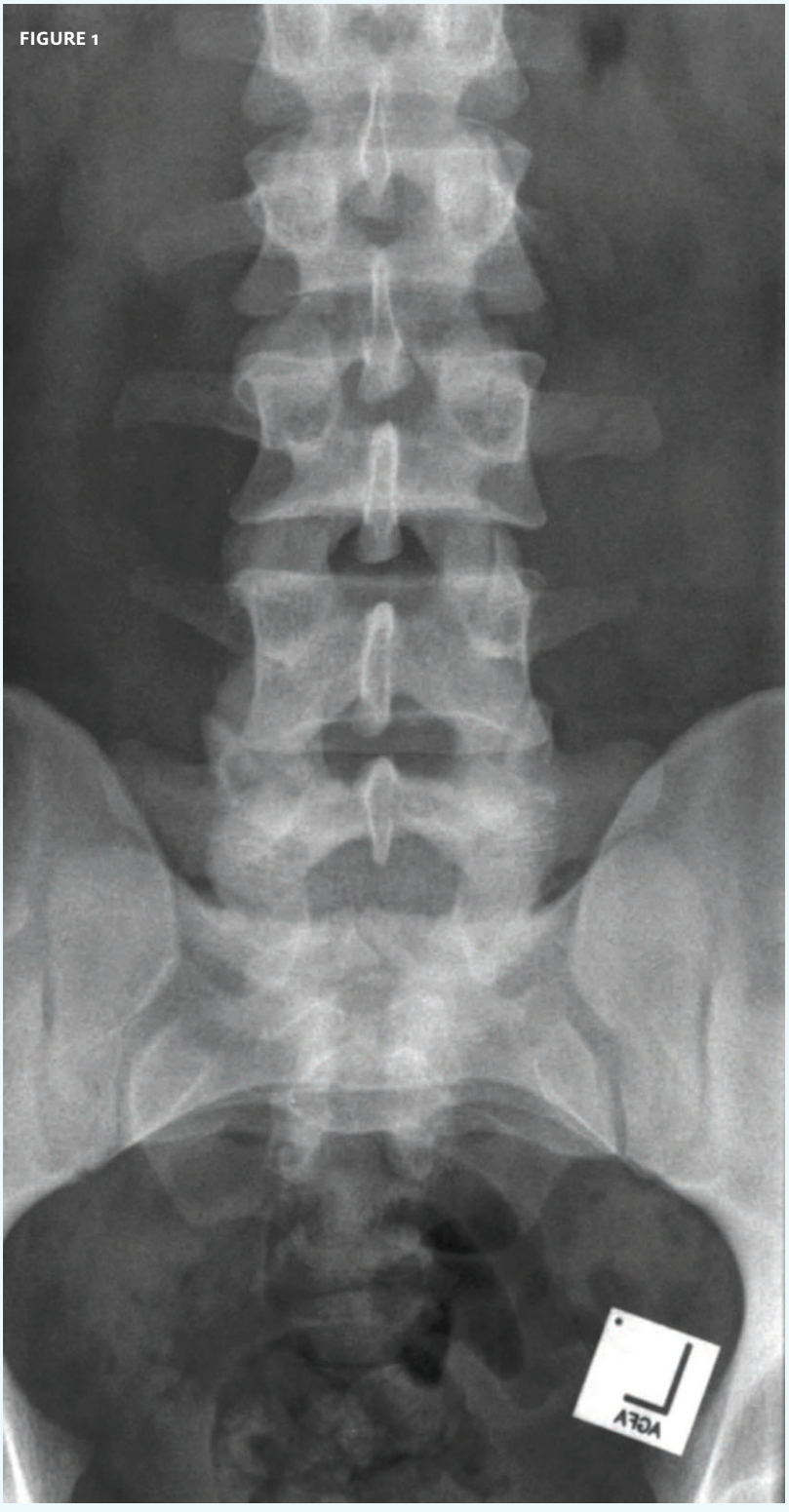
- The patient should first receive intravenous calcium chloride or gluconate to antagonize hyperkalemic cardiac effects.
- Sodium bicarbonate, dextrose with insulin, nebulized beta-sympathomimetics (as well as intravenous ones, including epinephrine) and intubation with hyperventilation shift potassium into cells.
- Loop diuretics (eg, furosemide) and potassium-binding resins (eg, sodium polystyrene sulfonate [Kayexalate]) increase potassium excretion, although dialysis is the best removal method for severe hyperkalemia.

Acknowledgement: Case presented by John F. O'Brien, MD, FACEP, Associate Professor of Emergency Medicine at the University of Central Florida School of Medicine and Florida State University School of Medicine, and Associate Residency Director of the Department of Emergency Medicine at Orlando Regional Medical Center in Orlando, Florida.

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 2

FIGURE 1



The patient, an otherwise healthy 22-year-old, fell on his back and now is experiencing significant mid-back pain.

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

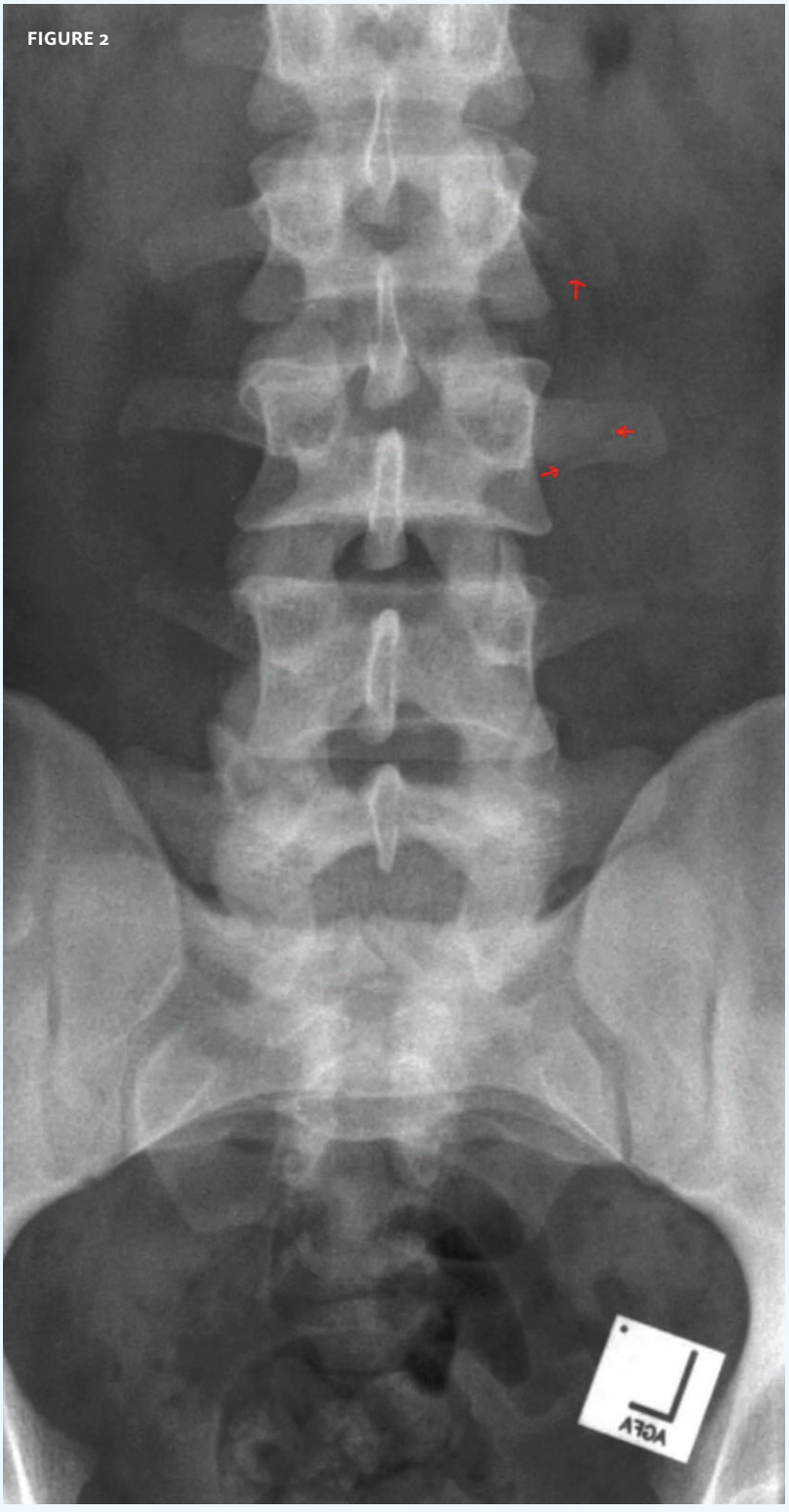


FIGURE 2

The patient's problem list includes trauma. The diagnoses are Fx, Fx vertebral.

This x-ray shows fracture of lateral process of the lumbar spines 2 and 3.

Lumbar transverse process fractures are commonly thought of as minor injuries compared with body, pedicle, and lamina fractures. As long as there is no evidence of abdominal injury or neurological deficit, these can be managed with pain control and orthopedic follow-up.

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

How to Get Sued for Malpractice: Four Studies In Self-Destruction

JOHN SHUFELDT, MD, JD, MBA, FACEP

In the past, I have written about how to *avoid* getting named in a medical malpractice action. But it can often be instructive to view things from the opposite perspective. So this time, let's turn it around and actually try to get named in a malpractice suit. It usually only takes one of the following misadventures:

- Practice bad medicine and have a bad outcome
- Practice good medicine, communicate/document poorly, and have a bad outcome
- Upset the patient or his family, or equally badly, have a staff member who upsets them, and *then* have a bad outcome
- Falsify or attempt to change the record no matter what the outcome

Here are four cases from my files that illustrate how easy it is to get yourself sued.

Bad Medicine and Bad Outcome

A 34-year-old female accountant presented at an urgent care center with a low-grade temperature, and she was feeling weak. The tech pushed her in a wheelchair to an exam room and took her vital signs, which were abnormal (pulse 120, respiratory rate 36, BP 100/42). The patient, however, was not thoroughly examined, no tests were ordered, and she was discharged with an anti-anxiety medication and told to rest.

The chart was poorly documented and not completed until the end of the day—after the clinic staff had learned of the patient's death from the medical examiner.

A chart review was performed after the center and provider were named in a malpractice suit. Based on vicarious liability, negligent supervision, and poor credentialing. The provider was named for his care, which was believed to be subpar. The defense could not find an expert who could support the care the patient received. Ultimately, both the center and provider agreed to pay the financial limits on their malpractice policy.

Poor care and poor documentation are the most common causes of malpractice suits. In this case, the young woman died of overwhelming sepsis secondary to pneumococcal sepsis. Had this happened after proper treatment and charting, the plaintiff's attorney would have had a hurdle to overcome to make the case on the basis of causation; if the diagnosis had been made correctly and the patient aggressively treated, the defense could then have argued that no matter what had happened, the patient's fate would have been sealed.

However, the case never made it that far. The care was so bad and the chart so poorly documented that the defense team offered the $2 million policy limit.

Lesson: use care paths, force yourself to document the pertinent negatives, and remember that as a provider, you may be the last person to have an impact on a patient with a life-threatening problem.

Good Medicine, Poor Documentation and Communication

A 47-year-old female presented to an urgent care with intermittent, right-sided chest pain that worsened with exertion, mild shortness of breath, and fatigue. She had a family history

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of coronary artery disease and was a smoker. Her exam and chest x-ray were normal. Her ECG showed non-specific changes only. No cardiac enzymes or other lab tests were drawn.

According to the patient's deposition, the physician verbally advised her to go to the emergency department for further evaluation. The note on her chart read: "Advised patient to go to the ED for further work up." The diagnosis in her chart was: "Chest pain, etiology to be determined."

The patient elected not to go to the ED that day for further workup. Three days later, she suffered an MI and underwent emergency angioplasty and stent placement; she was on a balloon pump for cardiogenic shock for about 16 hours. She ultimately survived, but her ejection fraction was only about 35%. The patient sued the provider for negligence on the theory that her care was below the standard.

A review of the care found the history, physical, and evaluation to be adequate, save that cardiac enzymes were not drawn in the urgent care center, as they should have been. The legal issue ultimately centered on appropriate informed consent. Was the patient advised of the risks of not going to the ED to complete treatment?

The plaintiff argued that although she may have been told verbally to go to the ED (which she denied), and although this advice was in her discharge instructions, the significance of abandoning her workup while still in progress had not been made clear to her. Had she known how bad the outcome could have been (and was) of not completing her workup, she certainly would have proceeded directly to the ED. The provider ultimately consented to a settlement and the plaintiff was paid an amount slightly below policy limits.

Lesson: when the patient has a condition that is causing or could cause serious morbidity or mortality, document the instructions thoroughly.

Staff or Provider Upsets Patient or Family

A 32-year-old male with a history of intravenous drug use presented at an urgent care for the fourth time in six days for low back pain. He stated that his pain was not improving and demanded more pain medication. Documentation on the triage note stated that the patient was rude and argumentative to the front office staff. His vitals at the time of treatment were: pulse 104, respiratory rate 18, BP 158/92, and temperature 39.0° C. Since it was the patient's fourth visit in less than a week and his complaints were generally unchanged, the provider performed a very cursory exam.

In addition, the provider confronted the patient about his previous IV and now prescription narcotic addiction, essentially accusing him of trying to feed a drug habit. The diagnosis on the chart read: "Back pain, narcotic abuse, and drug-seeking behavior." The patient was not given more pain medication. Instead, he was escorted in a wheelchair to the door and made to walk to his car.

Three days later, the patient was unable to ambulate, incontinent of urine, and in severe pain. An ambulance rushed him to the ED where he was found to have acute cauda equina syndrome from an epidural abscess. Ultimately, the patient underwent emergent surgery to drain his abscess. Despite aggressive treatment, he remained wheelchair-dependent and had to self-cath. He died 18 months later of complications from urosepsis, skin ulcers, and narcotic abuse.

The family sued the center and the provider, who both agreed to settle the case for policy limits after the care and documentation were reviewed and could not be supported by their expert.

Lesson: be nice. Life is too short—and the risks too high—to treat a patient (or anyone) disrespectfully; it always comes back to haunt you.

Falsify or Inappropriately Alter the Patient Record

This is a no-brainer way to get sued big time. No matter how good your care was or how much the patient was responsible for his outcome, if you alter or falsify the chart, you are going to get nailed.

A 14-year-old presented to an urgent care with abdominal pain. His vital signs were normal; a brief history was ascertained and documented. The physical exam was described in the chart as: "No tenderness to the mid-abdomen"; the rest was reportedly normal. The patient was discharged after a urinalysis was obtained and was "dipstick normal." His discharge instructions were: "Go to the ED for further tests. You may have appendicitis."

Two days later, the patient reappeared at the urgent care with a high fever, rigid abdomen, and peritonitis. He was seen by the same provider as before and immediately sent to the ED, where he underwent surgery for his ruptured appendix. After a rocky post-op course, the patient recovered completely.

The family sued the provider for failure to diagnose appendicitis on the first visit. A review of the care and the electronic record did not initially raise any red flags—until the plaintiff's attorney noticed a discrepancy in the discharge instructions and subpoenaed the actual electronic log of the medical record. This log revealed the time and date of all keystrokes entered into the chart, as well as who was logged into the record at the time.

Right after the patient was sent to the ED on the second visit, the provider went back into the electronic record of the patient's first encounter, which had not been closed out, and typed the word "No" before "tenderness to the mid-abdomen." He then deleted "F/U with PCP in a week," instead adding: "Go to the ED for further tests. You may have appendicitis."

Despite the patient's complete recovery, the insurance company agreed to pay policy limits and dropped the provider and center as clients.

Lesson: I can almost always find some redeeming aspects of a patient's care and treatment—until, that is, it is found that the chart has been altered. Then all bets are off. ■

CODING Q&A

Can an Urgent Care Use an ED E/M Code and Three Other Coding Challenges

DAVID STERN, MD, CPC

Our series on medical decision making in E/M coding will continue next month. This month, we address four challenging coding questions that *JUCM* readers submitted.

Q. Can 99283 and 99214 procedure codes be used for an urgent care visit? The codes were used by an urgent care facility, and I am told that 99283 is categorized as an emergency room code.

A. Code 99283 is for an emergency department visit for the evaluation and management of a new or established patient with an expanded problem focused history and examination and medical decision making of moderate complexity. Code 99214 is for an office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination and medical decision making of moderate complexity.

Code 99283 is reserved for use in an ED. Even if services are provided by a board-certified emergency physician, ED E/M codes should never be used in an urgent care, unless the urgent care is actually part of a licensed emergency department.

Both 99283 and 99214 would never be appropriate for the same patient encounter for at least two reasons:

- Only one E/M code per visit is appropriate
- The two codes indicate mutually exclusive services, since 99214 is for services rendered in a outpatient setting (appropriate for most urgent care centers) and 99283 is for evaluation services rendered in an ED.

Note: For urgent care centers that operate under POS-22, an E/M code may be billed on the CMS-1500 claim form for professional services and an additional (often different) E/M code may be billed on the UB-04 claim form for ancillary services. In this case, however, both E/M codes should come from the same set of E/M codes.

Q. A patient received minor surgery in our clinic (CPT code 12041: layer closure of wounds of neck, hands, feet, and/or external genitalia; 2.5 cm or less), and we also gave the patient an injection (CPT 90471: immunization administration; 90715: tetanus, diphtheria toxoids, acellular pertussis vaccine for use in individuals 7 and older). We used modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) with the 12041 code and modifier GA (waiver of liability statement on file) for codes 90471 and 90715. The payor denied CPT 12041 because the modifier was wrong. Can you tell me what modifier I should use for 12041?

A. The answer is much simpler than the question. Modifier -25 should only be appended to an E/M code, never to a surgical code.

Q. We can't get Medicare to pay for clindamycin 600 mg in our urgent care. We are using S0077 (injection, clindamycin phosphate, 300 mg). Is there another code we can use that Medicare will cover?

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity (*www.practicevelocity.com*), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.

A. S codes are codes that have been requested by *non-Medicare payors* for procedures or supplies that have no code in the CPT or HCPCS systems. The Centers for Medicare and Medicaid Services (CMS) creates the codes at their request, as required by HIPAA. S codes are specifically created for services or supplies that are not covered by Medicare. Thus, Medicare will always deny payment on an S code. There is no reimbursable code for billing Medicare for injectable clindamycin.

Q. **What CPT code would you bill for a visit with the doctor in an urgent care facility that resulted in a diagnosis of gastroenteritis with no other services rendered?**

A. Assuming the physician delivered and documented a face-to-face evaluation of the patient, it would be appropriate to code an E/M code based on the level of service documented in the medical record. If testing or IV hydration was performed, then additional CPT codes might be appropriate.

ABSTRACTS IN URGENT CARE

- Heparin-binding Protein
- Prostate Cancer Trial
- Hemodialysis: How Early?
- Overcrowding in the ER
- Guidelines for Treatment of Diabetic Neuropathy

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.

Heparin-Binding Protein: A New Biomarker for Bacterial Meningitis

Key point: A cerebrospinal fluid HBP level >20 ng/mL was 100% sensitive and 99.2% specific for bacterial meningitis in adults.

Citation: Linder A, Akesson P, Studahl M, et al. Heparin-binding protein: a diagnostic marker of acute bacterial meningitis. *Crit Care Med.* 2011;39(4):812-817.

To assess whether cerebrospinal fluid (CSF) levels of heparin-binding protein (HBP) can predict bacterial meningitis, researchers analyzed CSF samples in a prospective cohort of 145 adult patients with clinically suspected meningitis and in a retrospective cohort of 16 patients with bacterial meningitis and 13 patients with viral encephalitis at two hospitals in Sweden. Patients were divided into five groups: bacterial meningitis (41), viral encephalitis (19), viral meningitis (10), neuroborreliosis (7), and controls with normal CSF white blood cell counts (97 patients).

Median levels were significantly higher in patients with bacterial meningitis (376.0 ng/mL) than in those with viral encephalitis (5.0 ng/mL), viral meningitis (4.2 ng/mL), neuroborreliosis (3.6 ng/mL), or in controls (3.5 ng/mL). All but two patients with bacterial meningitis had levels >20 ng/mL. One patient with herpes meningitis and one with herpes encephalitis had elevated levels (40 and 41 ng/mL, respectively). In the prospective cohort (25 patients had bacterial meningitis), an HBP level >20 ng/mL had 100% sensitivity, 99.2% specificity, and 100% negative predictive value for diagnosing bacterial meningitis. Patients in all groups who died had markedly elevated HBP levels (>385 ng/mL).

Published in *J Watch Emerg Med.* April 15, 2011—Kristi L. Koenig, MD, FACEP. ■

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.

Randomized Prostate Cancer Screening Trial: 20-Year Follow-Up

Key point: Prostate Screening Adds No Survival Benefit at 20 Years.

Citation: Sandblom G, Varenhorst E, Rosell J, et al. Randomised prostate cancer screening trial: 20 year follow-up. *BMJ.* 2011;342:d1539.

Researchers randomized every sixth man in a Swedish city between the ages of 50 and 70 to screening every 3 years; the others underwent no screening. The study, begun in 1987, used digital rectal exam in the first two screenings, and then in 1993, screening for prostate-specific antigen was added. Suggestive results led to fine-needle aspiration biopsy. Outcomes were followed by using national registries of cancer and mortality.

The rate of prostate cancer diagnosis was higher in the screening group than among controls (5.7% vs 3.9%). Localized tumors were more than twice as frequent in the screened group, but the rate of non-localized tumors was similar between groups. Over 20 years, the prostate cancer-specific death risk ratio between groups was not significant. ■

Early Initiation of Hemodialysis

Key point: One-year mortality was higher with earlier than with later initiation, even in healthier patients.

Citation: Rosansky SJ, Eggers P, Jackson K, et al. Early start of hemodialysis may be harmful. *Arch Intern Med.* 2011;14(5);171:396-403.

Recent trends toward early initiation of hemodialysis (HD)—at estimated glomerular filtration rates (eGFRs) >10 mL/minute/1.73 m^2—have been driven by expectations that it would lower early morbidity and mortality in patients with end-stage renal disease (ESRD). Because prior studies were criticized for not controlling for comorbidity, researchers based this study on a US ESRD database of 81,000 HD patients (age range, 20–64) without substantial comorbidities other than hypertension; survival was assessed specifically among the 36,000 "healthiest" patients (those with serum albumin levels >3.5 g/dL).

In analyses adjusted for several clinical and demographic factors in the healthy cohort, death by 1 year was more common among patients who initiated HD at higher eGFRs. For example, compared with mortality in patients who initiated HD at an eGFR <5.0 mL/minute/1.73 m^2, mortality was 53% higher for patients with an eGFR of 10.0–14.9 and 118% higher for patients with an eGFR >15.0. These results corroborate those of a recent Canadian study.

Published in *J Watch Gen Med,* April 5, 2011—Thomas L. Schwenk, MD. ■

Do Mandates Reduce Emergency Department Overcrowding?

Key point: Some valuable lessons were learned from the National Health Service's 4-hour length-of-stay imperative

Citation: Weber EJ, Mason S, Carter A, Hew RL. Emptying the corridors of shame: organizational lessons from England's 4-hour emergency throughput target. *Ann Emerg Med.* 2011;57(2):79.e1-88.e1.

In response to emergency department (ED) overcrowding and long wait times, England's National Health Service (NHS) in 2005 mandated a maximum length of stay (LOS) of 4 hours for nearly all ED patients. Achieving the mandate resulted in financial remuneration, while failure led to undesired attention from the ministry of health. In 2008, the authors interviewed 27 leaders at nine NHS hospitals and identified common themes related to implementation of the mandate.

The percentage of ED patients with LOS <4 hours ranged from 76%-95% before implementation of the 4-hour mandate to 86%-99% after the mandate. At the time of the interviews, three hospitals had always performed well and continued to meet the target, three hospitals struggled for a few years before meeting the target, and three hospitals were still struggling to meet the target.

The interviews revealed four consistent themes related to implementation of the mandate:

- Interdependency (the need for system-wide involvement)
- Contrasting change management strategies between EDs (a collaborative effort) and the rest of the hospital (a more directive top-down approach)
- Staff burden and benefits (nurses were affected most by the mandate)
- Cost and risks of sustaining performance without compromising patient safety and medical education

Published in *J Watch Emerg Med,* April 8, 2011—Richard D. Zane, MD, FAAEM. ■

Experts Issue Guidelines on Treating Painful Diabetic Neuropathy

Key point: Pregabalin should be offered for the treatment of painful diabetic neuropathy.

Citation: Bril V, England J, Franklin GM, et al. Evidence-based guideline: treatment of painful diabetic neuropathy: Report of the American Academy of Neurology, the American Association of Neuromuscular and Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation. *Neurology.* Prepublished online April 11, 2011.

According to new guidelines from the American Academy of Neurology, American Association of Neuromuscular and Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation, Pregabalin should be offered for the treatment of painful diabetic neuropathy (level A evidence).

Among the other recommendations (level B or C evidence) published in *Neurology:*

- Anticonvulsants: gabapentin and valproate should be considered for treatment, while evidence is insufficient to recommend for or against using topiramate. Oxcarbazepine, lamotrigine, and lacosamide "probably" should not be given.
- Antidepressants: amitriptyline, venlafaxine, and duloxetine should be considered, and venlafaxine can be added to gabapentin. Evidence is insufficient to recommend for or against other agents (eg, fluoxetine).
- Opioids: dextromethorphan, morphine sulfate, tramadol, and oxycodone should be considered.
- Other pharmacologic agents: capsaicin or the Lidoderm patch may be considered.
- Non-pharmacologic methods: electrical stimulation should be considered, while magnetic field treatment is not recommended. ■

Dunkirk and Solomons, Maryland

Seeking part-time BC/BE EM, IM, and FP physicians to practice urgent care medicine at Dunkirk and Solomons Urgent Care Centers in Calvert County, Maryland. Enjoy a collegial relationship with nurses, mid-level providers, and urgent care support staff, excellent work environment, a flexible schedule, and competitive compensation.

Send CV: Emergency Medicine Associates
20010 Century Blvd, Suite 200
Germantown, MD 20874
Fax: (240) 686-2334
Email: Recruitment@EMAonline.com

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Lake Placid, New York

Looking to hire Physicians, Physician Assistants, or Nurse Practitioners to work in a fast-paced medical facility, practicing in either primary care or urgent care. We currently have four locations in New York: Lake Placid, Saranac Lake, Massena, and Malone. We are looking to fill full-time, part-time or per-diem positions.

Salary dependent on experience.

Email: ladams@mountainmedical.net

COLORADO MOUNTAINS - Physician wanted to join recently opened Urgent Care in Glenwood Springs. 3/4 position, 10-12 days per month. Time to enjoy your life. Partnership in 1-year old independent business. No cash buy-in required. Send CV: to JW@coloradosurgentcare.com

EXPERIENCED URGENT CARE PROVIDER - needed for busy facility. Profit sharing plans, premium benefits, paid malpractice, CME, vacation, signing bonus and salary paid up front! Aggressive packages including housing and car provided for the right candidate. No call, no pagers, no OB, work 3-4 shifts per week. Submit CV to: MDHR@MYDRNOW.COM

URGENT CARE IN NASHVILLE - Physician sought for new urgent care clinic to open in August in the Nashville suburb of Brentwood. Board certified physicians in family medicine, pediatrics, emergency medicine or internal medicine/pediatrics will be considered. Previous urgent care/emergency room experience preferred. Salary or hourly rate provided with malpractice and benefits. Contact Todd Dillon at 800-883-7345 or tdillon@cejkasearch.com; www.cejkasearch.com ID#140142C14.

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wanted to join privately owned, busy urgent care medical center in Highland, New York. Must be able to practice independently. A friendly, upbeat, caring personality is essential and at least 1 year emergency department or urgent care experience is required. Excellent compensation and benefits.

Reply: **Virginia (845) 691-3627**
Fax resume: **(845) 691-3641**

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Family Practice/ER physician needed for Urgent Care position in Huntley and Crystal Lake, Illinois. 12-hour shifts Monday-Friday, 9-hour shifts Saturday/Sunday. Competitive salary and benefits.

Interested candidates email resume to: mabraham@centegra.com

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If you are looking for an unsurpassed quality of life while pursuing an active, challenging medical career, then consider an employment opportunity in Charleston, West Virginia - a state that is rated as one of the top ten in the nation to practice. You will find that Charleston Area Medical Center has the best of both worlds if you are seeking the perfect life-work balance.

Charleston Area Medical Center and CAMC Physicians Group are recruiting for one full-time BC/BE Family Practice, Internal Medicine, Med/Peds or Emergency Medicine physician to join our Urgent Care team. The facilities have been in operation for more than 25 years, and we have four convenient locations. The hours of operation for three locations are from 9 a.m. to 9 p.m., seven days a week. The fourth is open Monday - Friday, 10 a.m. to 6 p.m. Candidate should have a full range of urgent care skills. Easy referral access to more than 400 subspecialists on staff at our medical center.

This outpatient opportunity offers flexible scheduling, work only 14 shifts per month and no call.

Our comprehensive benefits, enhanced compensation and productivity package as well as a generous sign-on bonus provide the opportunity to reach your financial goals quickly. Opportunity to work extra shifts if desired.

Affordable housing is located in safe and attractive neighborhoods and our school system is exceptional with both private and public school options. This is the ideal place to raise a family in a balanced and fulfilled lifestyle.

For consideration of our opportunity, please e-mail your formal CV to Carol Wamsley, Director, Physician Recruitment at carol.wamsley@camc.org. Toll free number: **866-551-8927**.

Charleston Area Medical Center | CAMC Physicians Group AFFILIATED WITH Charleston Area Medical Center

When you join the Mid-Atlantic Permanente Medical Group (MAPMG), you'll be able to get more out of your life and your career. As a physician-owned and managed multi-specialty group with over 900 physicians serving 550,000 patients at 30 medical centers, we know firsthand what it takes to advance professionally and thrive personally.

CHIEF OF URGENT CARE & URGENT CARE PHYSICIANS

We seek a Chief of Urgent Care in Baltimore, MD and Staff Urgent Care Physicians for our Baltimore/DC/Suburban Maryland and Northern Virginia locations. For the Chief opening, must be a BC Physician in Family Practice or Emergency Medicine who has or can obtain an active Maryland, Virginia and District of Columbia Medical License. Three years of team lead or supervisory experience is essential. Staff openings offer flexible schedules and require a BC Family Medicine Physician or BC Med/Peds Physician who has or can obtain an active Maryland, Virginia and District of Columbia Medical License. All positions require ACLS and PALS certification and computer/typing, advanced communication and organizational skills.

Join us and benefit from an integrated medical information system, excellent team approach, reasonable and predictable schedules, clinical autonomy, subspecialist support, energetic focus on excellence and comprehensive benefits, including 100% paid occurrence based malpractice, a pension plan and a 401K.

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Presbyterian Healthcare Services (PHS) is New Mexico's largest, private, non-profit healthcare system and named one of the "Top Ten Healthcare Systems in America". PHS is seeking four BE/BC Family Practice Physicians to work in our Urgent Care Centers. There are five Urgent Care Centers in Albuquerque and full time providers work 14 shifts per month or average around 144 hours per month.

Enjoy over 300 days of sunshine, a multi-cultural environment and casual southwestern lifestyle. Albuquerque has been recognized as "One of the Top Five Smart cities to Live." It is also is home to University of New Mexico, a world class university.

These opportunities offer: competitive salary * relocation * CME allowance * 403(b) with match * 457(b)* health, life, AD&D, disability insurance, life * dental * vision * pre-tax health and child care spending accounts * malpractice insurance, etc. (Not a J-1, H-1 opportunity) EOE.

For more information contact:
Kay Kernaghan, PHS
PO Box 26666, ABQ, NM 87125
kkernagh@phs.org
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- Excellent schools and safe living to raise a family
- Not a H1 or J1 opportunity

Contact: Amanda Krueger, Physician Recruitment Sourcer, for more information about this outstanding opportunity

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155 Crystal Run Road, Middletown, NY 10941
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Join this fast growing, physician run practice. Initial salary up to $125/hr with health benefits, 401K, malpractice, and more.

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Send resumes to:
physicianrecruiting@medcare-express.com

ATLANTIC Emergency Associates

ATLANTIC EMERGENCY ASSOCIATES URGENT CARE CENTER EMPLOYMENT OPPORTUNITIES FOR BOARD CERTIFIED PHYSICIANS

Atlantic Emergency Associates (AEA) is currently seeking BC/BE physicians to provide coverage at a **BRAND NEW** Urgent Care Center opened in Somers Point, NJ in conjunction with the AtlantiCare Physician Group. The center opened in May 2011.

The Urgent Care provides care for all non-life threatening emergencies, upper respiratory infections, minor fractures, simple lacerations, and other uncomplicated illnesses and injuries. Full plain radiograph capabilities and point of care testing are available. Exceptional support staff includes RNs and medical assistants.

AEA is an independent democratic physician group that provides services to the Emergency Departments of AtlantiCare Regional Medical Center in Atlantic City, Pomona and the satellite Emergency Department in Hammonton, New Jersey and now, the new 7-bed Urgent Care Center in Somers Point.

Our emergency medicine providers work in both the Atlantic City Campus (Level 2 Trauma Center) in Atlantic City, and at the Mainland Campus (Heart Institute) in Pomona, NJ. Both emergency departments are certified Chest Pain Centers, and certified Stroke Centers. We provide emergency care to more than 120,000 patients annually at these two facilities. Additionally we staff the Satellite Emergency Department in Hammonton 24 hours per day and the Urgent Care center located in Somers Point 11 hours per day.

Currently we are recruiting qualified candidates to cover the Urgent Care Center with full-time or part-time employment available. Additional coverage in the Emergency Department listed above can be offered to qualified BC/BE Emergency Medicine-trained candidates. Excellent salary and full benefits packages available to all new physicians. Scheduling equity in Urgent Care from the start.

If you are interested in further discussing this opportunity please contact:
John W. Becher, D.O., Chair, Emergency Services, john.becher@atlanticare.org or call Tom Walsh at 609-923-4315.
At your convenience, we will arrange your visit to Atlantic City. Please check our website – www.aeadocs.com

Urgent Care Physician

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As part of our continued growth, we are currently seeking outgoing **Urgent Care Physicians** to join our team in **Long Beach, Los Angeles, and Pasadena**.

In this role, you will have the opportunity to provide care and support to a wide variety of patients working in fast-paced Urgent Care Centers. Candidates should be Board Certified in Family Medicine, and be ACLS and PALS certified. Board eligible candidates will also be considered.

For immediate consideration or to learn more about our company, please email your CV to John Haigh at **jhaigh@healthcarepartners.com**.

You can also visit us at:
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For more information about employment opportunities, please contact:
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Medac Health Services, P.A.
4402 Shipyard Blvd., Wilmington, NC 28403
Phone: 910-452-1400 • Fax: 910-791-9626
Email: dkey@medachealth.com

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Chris Thompson
Physician Recruitment Program Manager
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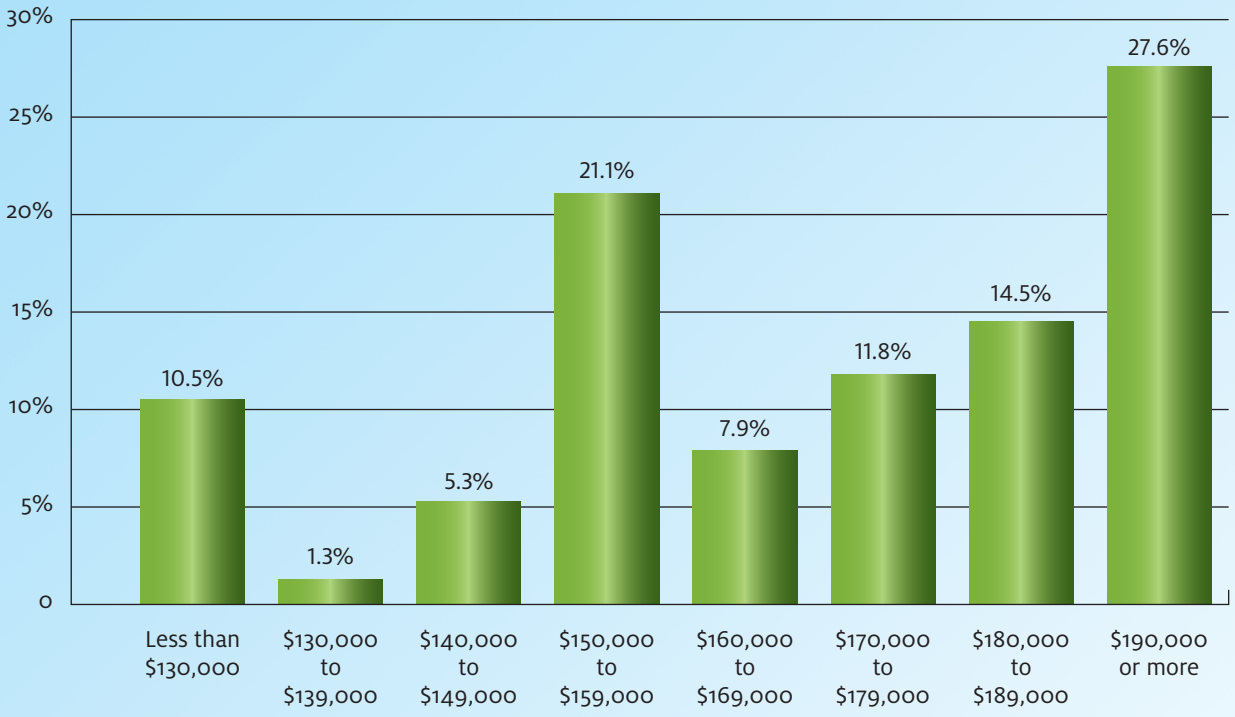
PRACTICE FOR SALE

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 a look at data from the 2010 Urgent Care Benchmarking Survey Results. These data are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to "full-fledged urgent care centers," the qualifications for which included accepting walk-ins during all hours of operation, as well as having a licensed provider on site, x-ray and labs on-site, the ability to administer IV fluids and perform minor procedures, and being open seven days a week, at least four hours per day.

In this issue: How well were urgent care physicians compensated in 2010?

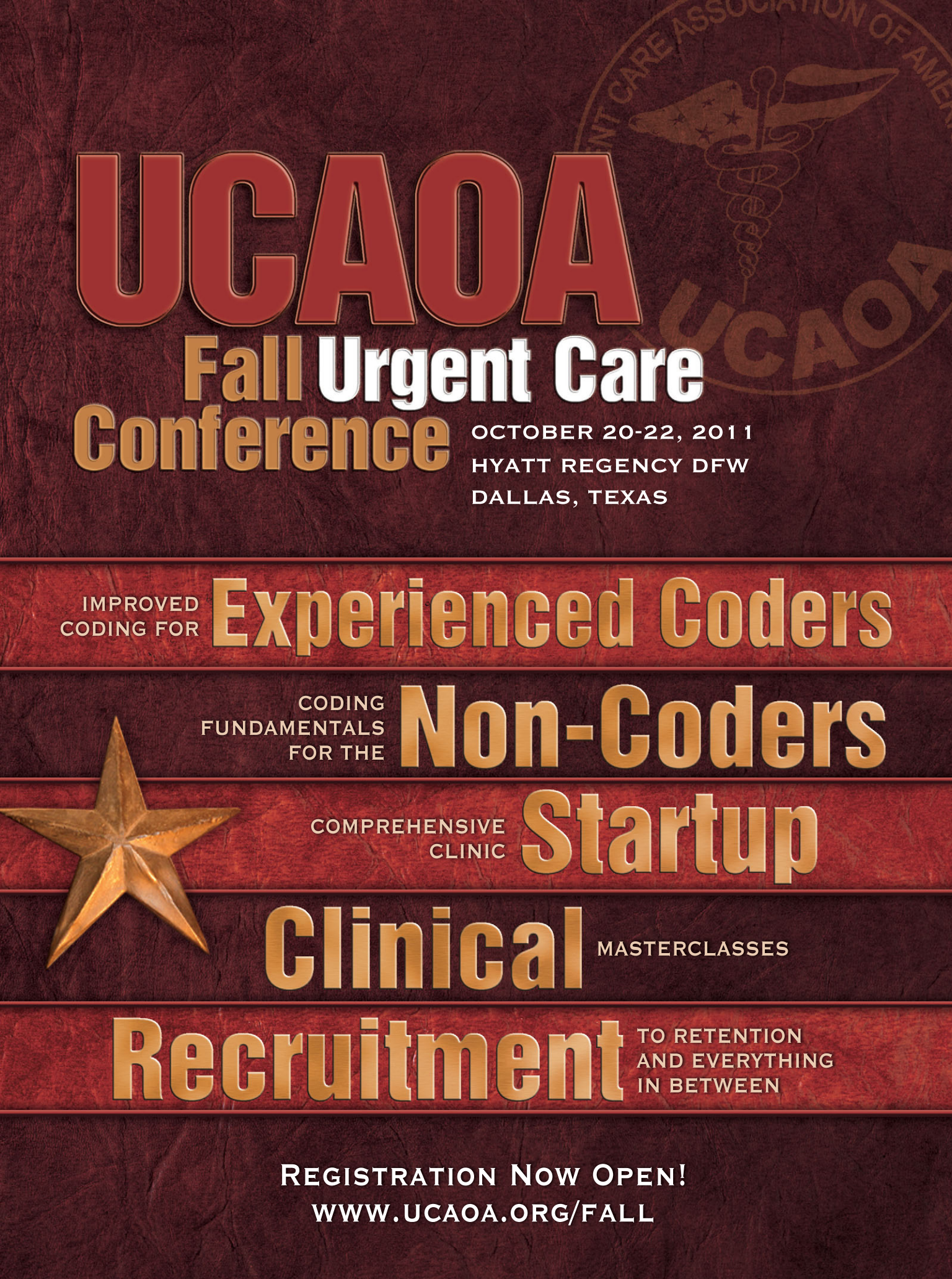
COMPENSATION



In the 2008 Urgent Care Benchmarking Study, the average physician salary per year was $158,845. No other salary information was included in that survey. In the 2010 survey, which measured the percentage of doctors earning less than $130,000 to more than $190,000 a year, more than half (51.8%) earned $160,000 or more a year, with the largest number by a considerable margin (28%) earning $190,000 or more a year. The median compensation range for urgent care physicians in 2010 was $170,000-$179,000 a year.

Acknowledgement: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at www.ucaoa.org/benchmarking.

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