LETTER FROM THE EDITOR-IN-CHIEF

Keeping the Joy of Practice

Many physicians in urgent care face burnout. While the numbers are probably far less than our emergency medicine colleagues, the burdens of productivity, quality, patient satisfaction, employee satisfaction, and risk management can weigh heavily on urgent care physicians, and with time, take the joy out of practicing. This is the first in a series of editorials providing practical tips for reducing "urgent care fatigue syndrome."

Let's start with an approach to managing patients who are antibiotic and narcotic seekers: make a dent in the armor / you can't win the war in one visit / live to fight another day. Attempting to right all the wrongs in the world is a surefire way to burn out or lose your job to poor productivity.

Case 1: 'Recurrent Sinusitis'

This patient arrives in the urgent care for "recurrent sinusitis," but it becomes clear during the history that this patient is undoubtedly receiving multiple courses of antibiotics inappropriately, has never had an appropriate work-up, and has never been given an evidence-based treatment plan. She has been conditioned to pursue antibiotics when she feels this way.

You could do "battle" with this patient on inappropriate antibiotics, but I can guarantee you she will reject your theory and go to other caregivers who will make you look bad by giving her the antibiotics anyway. You will have accomplished nothing by way of reducing antibiotic use this way. Here's an alternative that will save you the speech, and maybe recruit her onto the side of sensible antibiotic use:

"You seem frustrated that you keep getting 'sinus infections' requiring multiple courses of antibiotics. I think we need to recruit a specialist to help find out why, and to develop a treatment plan for whenever you get 'sinus symptoms' so you don't develop resistance, but still get appropriate treatment when you need it. Ask the specialist exactly when you should start antibiotics and when you should just treat symptomatically. We need to give you more clear guidance, so that you can feel sure you are getting the most appropriate treatment."

Even if you give this patient an antibiotic this time, you have made a dent in her psyche without offending her. Referring this patient to an ENT whom you trust will provide her with a long-term management plan that is consistent with established guidelines.

Case 2: Migraine Headache, 'Needs Demerol'

Everyone dreads this encounter, but this is an opportunity to impact this patient's care for the future.

I have found that the majority of these patients are victims of poor medical care, and are *not* drug seekers. They have been conditioned by providers who have never explained migraine management or the importance of a treatment plan from a migraine specialist. Most of these patients are indeed out of the window for effective triptan use anyway.

After thorough neurologic evaluation for alternative causes, I say this: "The use of narcotics for migraines is a last resort for most patients. I am concerned that you have not been given an effective prevention and treatment plan for your migraines, which may be contributing to your frequent, debilitating attacks. Because narcotics are rarely used for migraine management, we have a policy requiring an order from a headache specialist highlighting your treatment plan, should they be necessary on an ongoing basis."

This avoids the battle, presumes innocence, and protects against the real drug seekers. At our clinics, we have no return offenders with this policy and never meet any resistance from patients. Most are simply grateful that we took a genuine interest in their well-being. The same approach can be taken for the other common narcotic requestor: the "back pain" patient.

In future editorials, I will address the following important contributors to career durability and satisfaction:

- Understanding patient agendas
- Communication tools for more effective patient encounters
- Filling your "emotional tank"

Sincerely,

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