'What Happens If We Do Nothing?' Is Still the Right Question

"It only hurts right here," Rich told me, pointing to a tender spot on his ribs under his arm pit.

I palpated his chest wall and observed as he winced when I hit the spot.

"I just need to make sure I'm okay to go back to work."

Rich was middle-aged and had a mustache with hints of grey. He was a large man, but his potbelly was overshadowed by his towering height. He had a polite, unassuming demeanor and came in wearing his uniform for the mechanic shop he worked in, complete with his name embroidered on the chest and a collage of grease stains. He'd left work to come to urgent care (UC) to get a note clearing him for work after slipping and falling on some steps the night before. It was clear he didn't want to be here.

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"How's the pain? Have you taken anything for it?" I asked.

"Just some ibuprofen. It's manageable," he said.

I recommended we get a chest x-ray to make sure he hadn't punctured his lung. He somewhat reluctantly agreed. It was clear anything I suggested was going to seem like overkill to him.

Not surprisingly, his x-ray showed no pneumothorax, hemothorax, or lung contusion. I thought I might be able to make out a single rib fracture, but I didn't see any reason to keep him any longer. I knew he was more eager for the discharge conversation than I was.

As I got ready to discuss the "good news," with him, I reviewed his vitals. His blood pressure (BP) was 197/115. Maybe it was just the pain, I thought. So, I looked back at his pressures from infrequent prior visits over the last 5 years or so: 175/108; 182/101; 173/99. It was clear this was more than just the adrenaline from his rib pain driving this. Looking through his chart further, I found no mention of his elevated blood pressure or any documented history of hypertension. He was only taking metformin for diabetes. Then I saw his last HbA1c; it was over 10. It seemed like there was more than the rib fracture I needed to discuss with Rich.

I went back to the exam room and found him standing at the doorway with his coat on. He was clearly only waiting for his note for work. "How often do you check your blood pressure and blood sugar?" I asked.

"I don't check either. They check them for me if I go to the doctor's," he said. It turned out this wasn't very often.

We see patients like Rich every day in UC, and we find ourselves in similar situations as this almost as frequently. He was in a hurry, I was in a hurry. The immediate issue had been assessed, and we both had other things to do.

I imagine if you polled a group of UC clinicians about how they'd address his undiagnosed hypertension and poorly controlled diabetes, many would say they wouldn't. Perhaps some would comment on his high BP and that he should see his primary care provider about it. However, I am certain that most UC practitioners would spend several minutes—likely the vast majority of the interaction—discussing the suspected rib fracture and things like bracing, incentive spirometry, pain control, and cautions around developing pneumonia. After all, it's why he came in that day. But while it's undeniable Rich presented for his rib injury, it was arguably the least important topic to discuss.

My October 2023 editorial entitled "What Happens If We Do Nothing?" presented an argument for doing *less* rather than more for the majority of the acute issues that land on our doorsteps.[1] I contended that most UC patients are at higher risk of adverse outcomes by us ordering questionably indicated tests and medications. This position, while potentially controversial, is based on the undeniable premise that most UC presentations represent minor, self-limited conditions (eg, lumbar strains,

minor skin infections, sinusitis etc.). Appreciating the self-resolving nature of these issues alongside the prospect of doing harm though intervention, I alluded to the important and juxtaposed concepts of natural history and iatrogenic potential. For minor, self-limited problems, the natural history is full recovery, and therefore, the potential risks of most testing and treatment are not justified because our patients are typically very likely to recover fully regardless. An isolated rib fracture from minor chest trauma in a middle-aged patient is another example of such a condition.

However, while most patients elect to visit UC for acute issues, undiagnosed or inadequately managed chronic conditions commonly become apparent through the course of our assessments. This was the case with Rich. Additional issues that present high-yield opportunities for affecting our patients' future health outcomes include obesity, overdue cancer screening, safer sex practices, and substance use patterns (eg, tobacco and alcohol consumption). Although these issues are rarely the sole impetus for UC visits, we ignore them at our patients' peril, and we know what happens if nothing is done about them. Cardiovascular disease and cancer are the two leading causes of death in the U.S. Stroke, diabetes, liver failure, lung disease, and dementia also make the top 10 list. Whereas dying from sinusitis, urinary tract infection, or a rib fracture, unsurprisingly, aren't.[2] We know, with as much certainty as is possible in medicine, that these chronic health conditions and lifestyle choices, however, are clearly major contributors to premature morbidity and mortality.

Our primary duty in UC is indeed to address patients' proximate concerns and exclude immediate life threats. But to be honest, we can do this for most patients in a matter of a few moments. This is, however, when we reach the critical decision point: Do we stop there and move onto the next patient, or do we invest an extra moment and a bit more effort to do something that can really make a difference in a patient's life?

Addressing Versus Managing

When we take our cars in for an oil change, it's common practice for the service technician to comment on the overall "well-being" of our vehicle. In addition to changing the oil and filter, we may be told that the brake pads are wearing thin or the timing belt is fraying. This information is incredibly valuable, even though it isn't especially relevant to the reason we stopped in for service, because these mechanical issues are looming disasters for our car's mechanical function and our safety. While we don't hold the technician solely responsible for remedying every problem they find then and there, most of us would feel betrayed if these issues were to be identified but not communicated with us. With less expertise in automotive maintenance and repair, we become accustomed to the way our cars handle and are insensitive to small changes that accrue over time. It often takes an objective and expert eye to recognize impending disasters.

Similarly, our patients rarely present to UC to discuss chronic health conditions. Rather, they present with what they feel is a discrete need: a new symptom needs evaluation, a medication needs to be refilled, or they feel they should have a specific test. Increasingly, fewer of our patients have a primary care clinician, and we may be their only contact with the healthcare system for months or years.[3] Like the auto mechanic, we often quickly identify looming trouble for our patients' health (eg, uncontrolled hypertension, severe obesity, etc.). But this undeniable reality does not imply that we are obliged to "fix" these chronic issues (nor should that be our patients' expectation). However, we are as remiss as a reticent repairman if we do not at least draw the patient's attention to the concerning nature of what we observe and convey what's likely to happen if the problems are ignored.

Many UC clinicians may balk at the idea of having any responsibility in such scenarios. "This isn't our job," is a common refrain. Yet, if we are concerned about the well-being of our patients, that argument doesn't really hold water. There are many cracks in the American healthcare system—and indeed most nation's healthcare systems—however, focusing on these deficiencies does little to protect the health of our patients.

There is also a common sentiment that counseling about health behaviors and lifestyle changes in the acute care setting is overly time consuming and futile.[4] However, we often underestimate the effect of these brief (ie, 1-2 minute) interventions.[5] This is likely largely because without continuity with our patients, we don't see the effects of our efforts. We plant the seeds, but we don't get to see them grow. It's worth remembering however, as Warren Buffet said, "Someone is sitting in the shade today because someone planted a tree a long time ago."

Conversely, if we ignore these chronic situations that we know pose significant risks for longer term outcomes, we send an implicit message that they're really not so important. If you're a parent and you catch your teenager with a beer, not calling it out sends the message that "drinking is okay." Our patients, whether either of us realize it, look to us for guidance and therefore, saying nothing when an unmitigated chronic problem is apparent is meaningful.

Ticking Time Bombs

As UC is increasingly becoming patients' lone interface with healthcare practitioners, it is worth scrutinizing how we approach these obvious "ticking time bomb" situations.

Again, the question, "what happens if we do nothing?" becomes critical. Since we've all chosen UC because we care for our patients, we must offer prescient warnings when we see where their stories are heading. In an ideal world, these responsibilities wouldn't fall on our shoulders, but we practice in world and healthcare environment that is tragically short of perfect.

The reality of UC practice is that we have precious little time with each patient, so our greatest perpetual duty is to spend each moment in the most meaningful way possible. Had I focused only on Rich's rib fracture, he would have been perfectly content to continue on with his day and life. He may have even given me a 5-star review for getting him in-and-out so quickly. However, I believe we are called to look beyond asking ourselves, "What do I need to do for the issue this patient came in for?" Instead, we should consider the natural history of whatever long-standing medical issues we inadvertently uncover and again ask ourselves, "What happens if I do nothing?" Because if we don't, then who will?

References

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Joshua W. Russell, MD, MSc, FCUCM, FACEP
Editor-in-Chief, *JUCM, The Journal of Urgent Care Medicine*
Email: editor@jucm.com • Twitter: @UCPracticeTips