LETTER FROM THE EDITOR-IN-CHIEF

Our Success in Urgent Care is Defined by How We Play Our 'Greatest Hits'

Recently one evening, I meandered into a bar on iconic 6th Street in Austin, Texas— America's epicenter for live music. Venues throughout the district feature free, live performances every night from some of the nation's most talented musicians. On that particular evening, however, the sounds from one electric guitar coming from a small stage in a dark room cut through the humid air and grabbed my attention. I wandered in, found a seat at the bar, and took in the guitarist's performance. He was nothing short of a master. His look and style reminded me of a young Stevie Ray Vaughn, and he played with similar virtuosity.

As a hobby guitarist myself, what most impressed me, as I watched his fingers move nimbly and effortlessly up and down the neck of the instrument, was his ability to launch into any requested song without hesitation. He only paused long enough between tunes so he could hear the shout of the next request. Then an instant later, he was onto another flawless rendering of whatever song was suggested, from Led Zeppelin to Bob Marley to Johnny Cash to Metallica. The alacrity and deftness with which he switched between styles reminded me of a polyglot switching between languages with each sentence. Watching this level of talent and range on the guitar was humbling to say the least.

We are at liberty to define success however we see fit

Achieving Mastery

I've heard comparable sentiments from newly minted practitioners as they contemplate careers in urgent care (UC): After seeing a master UC clinician in action, practicing in UC seems understandably daunting. Since the fall of 2023, I've had the privilege to serve as one of the lead instructors for an UC clinical fellowship program for new graduate advanced practice practitioners (APP). These fellows have completed their APP schooling and received their licenses. In the eyes of their respective boards, they've met all the benchmarks required for (relatively) independent practice. However, simultaneously, our fellows also realize that it would be extremely stressful to dive headlong into UC practice without additional training—not to mention also potentially precarious for their patients.

While the fellowship lasts a full year, many of the trainees I work with still feel apprehensive about their ability to achieve mastery over that time, and that worry is justified. Reaching high-level fluency during a training period of this duration is unrealistic, if not impossible. The shortest physician residency programs involve 3 intensive years of supervised education after successful completion of medical school. Yet, I can still clearly recall exiting my training program feeling incompletely prepared for independent practice.

However, UC centers nationwide are facing clinician shortages and simultaneously continuing to move increasingly toward an APP-dominant staffing model. While the number of licensed APPs in the U.S. is undoubtedly growing, there remains a chasmic shortfall of those with UC experience and proficiency, leaving many UC organizations stuck in a state of perpetual understaffing.[1,2,3] If leaders for UC centers wish to keep up with this demand, some form of on-the-job training, like the fellowship program mentioned above, likely needs to be at least part of the solution.

The question then becomes: What is the appropriate goal for these training programs? It's a critical question to answer because the expense of paying senior clinicians for supervision and didactic time can be considerable, especially when such programs arguably need to be 6-12 months in duration at minimum. In other words, how can UC leaders feel confident in knowing when newly minted clinicians and those without prior UC experience are ready to be released into the wild?

As there is no board certification for physicians or

equivalent certification for APPs, we've been left to figure this out for UC on our own. A number of possible solutions for determining clinicians' readiness for independent UC practice have been explored. These methods range from direct observation to chart audits to administering of proprietary competency tests. While there are cogent arguments for each of these tactics, alone or in combination, ultimately all permutations of assessment fall short of offering suitable assurance of a clinician's competence. Inventor Charles Kettering said, "a problem well stated is a problem half solved." Getting to a solution therefore depends on better elucidating the problem. So, let's distill the situation a bit further.

Clinical Competence in UC

What are the requisite components for clinical competence in UC? Sufficient proficiency requires, first and most obviously, an appropriate breadth and depth of clinical knowledge. Second, of equal importance, but less self-evident is the need for efficient decision making. With this combination, confidence can emerge. Without this form of appropriate confidence, clinicians simply will not be independently able to function at a level to allow them to handle the ubiquitous 40+ patient shifts.

So, to explore the issue further, the next question becomes how can we fast-track trainees towards a state of sufficient confidence to allow for them to keep patients safe and find the work sustainable? A significant source of this ongoing uncertainty seems to arise from the discrepancy between the novices' own level of performance and that of the seasoned UC clinicians they observe.

They're having the same experience I had while sitting in front of that small stage in Austin, watching the masterful guitarist with awe. If I believed "success" with the guitar meant matching his level of mastery, I'd be frozen and riddled with self-doubt as well. The power of success as a concept is that its definition is necessarily subjective. With thoughtful reflection, we are at liberty to define success however we see fit. While I greatly admired that musician, I realize I'll never play the guitar like him; I could very well inadvertently define success as such. In fact, it may even be human nature to do just that. If that had become my new bar for success as a guitarist, it would've seemed so unachievable so as to dissuade me from even practicing. Rather, since I've chosen personally to define success in this pursuit only as continuous improvement, I'm thankfully not left feeling hopelessly resigned to failure.

Clinical competence in urgent care medicine is exactly like this. We don't need the ability to play any song that's requested of us flawlessly. Instead, we simply need to be able to perform like a solid cover band. There is a social contract between cover bands and audiences, and it is a perfect analogy for the duty we have to our patients in UC. So let's explore this metaphor a bit further.

If you see a Grateful Dead cover band play a show, you know what to expect. The band likely will be playing songs only found on Grateful Dead albums. They probably won't be honoring requests for Guns 'n Roses tunes. On the flip side, however, we would rightfully expect for the musicians to be comfortable with the majority of the Grateful Dead's catalog, especially the hits, and to be able play those songs well. They wouldn't be violating the cover band social contract if they declined to play "Hey Jude," but they most certainly would be if they butchered "Friend of the Devil."

Similarly, it is not incumbent upon UC clinicians to diagnose and treat every ailment known to humankind. We are responsible only for mastering the catalog of conditions that fall into the category of acute, minor illnesses and injuries. Certainly, having familiarity with chronic and more life-threatening conditions has utility as well, but this is not requisite to fulfill the responsibility we have to our patients. There is tremendous power in this realization. Developing this awareness, liberated me from considerable angst I used to feel at work because it made the ask seem achievable.

Urgent Care's Greatest Hits

It's important to recognize the corollary of this expectation as well, however. While our expertise in every specialized area of medicine is not required, like the cover band, we are expected and required to be experts in what our "audience" shows up for: care for the common, lower acuity, acute presentations that we see on a regular basis. These include conditions like sinusitis, cough, dysuria, low back pain, ankle and wrist injuries, and vomiting, just to name a few. I call these "Urgent Care's Greatest Hits," and we must have the skills and knowledge to play them all with alacrity whenever we're called upon.

Thankfully, just like any cover band, we don't need come up with entirely new songs on our own. The greatest hits of UC exist in the form of clinical guidelines, most of which are supported by reasonably high-quality evidence. When we diagnose acute otitis media in a child, we don't have to figure out who to treat with antibiotics, for how long, and with which drug, based only on our experience and clinical reasoning. The American Academy of Pediatrics has outlined exactly how that "song" should sound. We just have to play it as it was

written.[4] Refraining from taking too many creative liberties with these guidelines is actually how we serve the audience (ie, our patients) best. This should offer consolation as it places discrete and attainable parameters on how broadly our expertise is expected to extend.

I've seen a few lackluster cover bands over the years, and they've all failed in the same ways. They didn't perform the songs they should've had down cold very well, either because they weren't as familiar with the music as they needed to be or because they took too much artistic license with their interpretations. Many UC clinicians unfortunately stumble in an analogous way. While the Infectious Disease Society of America (IDSA) guidelines on treating acute sinusitis—one of the most common conditions we see—clearly don't recommend antibiotics in afebrile patients with less than 10 days of symptoms, it is a relatively common practice to prescribe antibiotics for shorter duration sinus symptoms. Similarly, the same guidelines recommend amoxicillin-clavulanate or doxycycline for 5-7 days in adults meeting criteria for possible bacterial sinusitis, yet frequently many providers still reach for a Z-Pak or amoxicillin alone or opt for 10+ days of therapy – an unjustifiably long course of treatment.[5] Similarly, dissonant renditions of the treatment of acute bronchitis with antibiotics and non-radicular low back pain with steroids can also be heard coming from many UC centers with troubling frequency.

When I've raised concerns with the providers I supervise about the potential harms and lack of evidence basis for such care, I've often been met with resistance. The most common justification I hear in these settings for deviation from the guidelines centers around a perception that the stakes are low and deviations small. Ergo, the differences from best practices don't matter. While the consequences may be unapparent for any given patient, being able to treat these conditions correctly is truly the reason for urgent care's existence. If a Grateful Dead cover band consistently played a G instead of a C chord in the chorus of "Casey Jones," the difference in the song may not be apparent to every listener. However, this oversight more globally would suggest that the band was not terribly attentive to the quality of their performance, and most concerningly when playing a song that should be their core strength, or about the ex-

perience for their audience in general.

By its very nature, the vast majority of UC presentations are low acuity; many are even self-limited. However, what our patients are experiencing matters to them. That's why they seek our expertise. And most of the time, they've come to the right place. Over 95% of patients presenting to UC centers are not referred to an emergency department, and the 20 most common diagnoses made in UC comprise well over half of all visits.[6,7] In other words, most of our patients come in for problems that we can and do treat every day. So, while what's at stake for any individual case may seem inconsequential, if we choose to prescribe a less effective, more risky, more costly antibiotic for a longer duration than recommended for conditions we treat on a daily basis, like cystitis or sinusitis for example, this will lead to thousands of inappropriate prescriptions over the course of a career. Collectively, this will certainly lead to a not-inconsequential number of avoidable adverse outcomes and unnecessary patient expense.

Adopting this philosophy into practice is not only good for our patients, but it's also good for us as UC clinicians as well. Apart from limiting possible anxiety about harming our patients or facing any legal repercussions if they experience a bad outcome, when we invest in improving our fluency with UC relevant guidelines, this contradicts any narrative we may be carrying about the stakes in UC being too low to matter. Furthermore, there's certainly more job satisfaction to be found when we convince ourselves that the care we deliver in UC actually is important and valuable—which I firmly believe is the case.

Amazing Performance

This shift then begets a virtuous cycle: If we believe the quality of our care matters, we're more satisfied with our job. This puts us in a better mood at work, which in turn will be undoubtedly detected by our patients and staff, who will then be more at ease and more pleasant to care for and work with. We can notice a similar phenomenon if we catch a particularly engaging cover act. Doesn't everyone watching the band seem to enjoy themselves more when watching that kind of energetic performance? Sure, the group may be playing "Truckin'" for the 50th, 500th, or 5,000th time, but if they still are playing it like they care about the audience's experience, it makes for an unforgettable show—and this doesn't require an elite level of musical talent either. Rather, amazing performance simply requires knowing the songs that the audience expects to hear and playing them well and with enthusiasm.

If we look at UC through this same lens, what's required of us to achieve proficiency as UC clinicians hopefully now seems more manageable. As a substantial bonus, discovering new-found joy in work will likely arise incidentally as well. Organizational psychology research on this topic has confirmed a clear association between a worker's level of competence and their job satisfaction.[8] So, if you're feeling burned out or ineffectual, it might be worth asking yourself where you can refine your proficiency within the core UC "set list." Committing to simply improving your performance of this limited catalog is likely to yield an increased sense of effectiveness and enjoyment for work. And you likely won't want to stop there because, just like the journey of improvement for musicians, there is infinite room for growth as a clinician—especially if we start by rethinking our definition of "success." ■

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